S. HRG. 104–139

IHS IMPLEMENTATION OF THE SELF-GOVERNANCE DEMONSTRATION PROJECT

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

OVERSIGHT HEARING TO FOCUS ON HOW THE INDIAN HEALTH SERVICE IS IMPLEMENTING THE TRIBAL SELF-GOVERNANCE ACT

MAY 2, 1995
WASHINGTON, DC

U.S. GOVERNMENT PRINTING OFFICE

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INDIAN HEALTH SERVICE IMPLEMENTATION OF THE SELF-GOVERNANCE DEMONSTRATION PROJECT

TUESDAY, MAY 2, 1995

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:29 a.m. in room 485, Senate Russell Building, Hon. John McCain (chairman of the committee) presiding.

Present: Senators McCain, Inouye, Wellstone, and Campbell.

STATEMENT OF HON. JOHN McCAIN, U.S. SENATOR FROM ARIZONA, CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

The CHAIRMAN. Good morning.

This oversight hearing will focus on how the Indian Health Service [IHS] is implementing the Tribal Self-Governance Act. I know that some of the witnesses had to pay a high price in terms of money, time, and family obligations to appear here today, and I want you to know that I appreciate that.

I am persuaded that tribal self-governance will provide the framework for Federal Indian policy in the future. Self-governance is a policy conceived by tribal leaders. It gives practical meaning to the special trust relationship between tribes and the United States by requiring government-to- government negotiations, increased tribal flexibility, and a transfer of control from Federal bureaucrats to tribal governments who are closer to the people served.

Last year, Congress declared the Interior Department's self-governance demonstration project to be a success and enacted a law to make tribal self-governance a permanent program. We will soon consider legislation to make tribal self-governance a permanent program at the Indian Health Service.

It appears that the implementation by tribes of health-related self-governance efforts has been largely successful. It also appears that much more remains to be done by IHS to remove Federal obstacles to full implementation by tribes.

I could say much more about self-governance, but instead I want to hear from the Administration's witness and the witnesses from the tribes. Last night I was able to read the written testimony of each witness, except for that of the IHS; accordingly, I ask that each witness keep your oral remarks brief, highlighting your main

points, so that I and other members of the committee have time to ask you questions.

The committee did not receive the IHS testimony until yesterday evening. I hope that in the future they will comply with our request to provide testimony in a timely fashion.

With that I would like to welcome our first witness, Michel Lincoln, who is deputy director of the Indian Health Service.

Mr. Lincoln, I understand that Director Trujillo could not make it due to a death in his immediate family. Please extend to him our sympathy and understanding.

Please take the witness stand.

This hearing this morning will be chaired by Senator Ben Nighthorse Campbell, and I appreciate his willingness to do that. I think he is uniquely qualified, especially on the issue of self-governance, as Senator Campbell was the earliest and foremost advocate of tribal self-governance and one who has had a long and unique experience on this issue. I don't believe we would be where we are in our effort to fully realize tribal self-governance if it were not for Senator Campbell's dedicated work for many years.

I appreciate your chairing the hearing this morning, Senator Campbell. With that, I turn the hearing over to you.

Senator CAMPBELL [assuming Chair]. Thank you, Mr. Chairman. I will submit a statement for the record.

Just let me say that what started out as a demonstration project from my perspective has worked very nicely and many of the tribes are finding that they can implement a lot of the programs that used to be administered by the Bureau. That's one of the reasons I have always been supportive of it.

But I know that we have a number of witnesses. I don't want to take a lot of time, as you didn't. I have to preside in a little while, so we'll just get right on with it, if we could.

[Prepared statement of Senator Campbell appears in appendix.]

Senator CAMPBELL. We will first hear from Michel Lincoln from the Department of Health and Human Services.

If you would like to start, just go ahead, Michel.

I might tell all the people testifying that all your complete statements will be included in the record, if there is no objection, so if you would like to abbreviate your testimony, feel free to do so.

STATEMENT OF MICHEL E. LINCOLN, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROCKVILLE, MD, ACCOMPANIED BY LUANA REYES, ACTING DIRECTOR OF HEADQUARTERS OPERATIONS; REUBEN HOWARD, ACTING DIRECTOR, OFFICE OF TRIBAL SELF-GOVERNANCE; AND DOUGLAS BLACK, ASSOCIATE DIRECTOR, OFFICE OF TRIBAL ACTIVITIES

Mr. LINCOLN. Thank you, Mr. Chairman, Senator Campbell. I am joined here today by Luana Reyes, to my left, who is the acting director of Headquarters Operations in Rockville, MD; also, Reuben Howard, who is to my immediate right, who is the acting director of our Office of Tribal Self-Governance; and Douglas Black, who is our associate director of our Office of Tribal Activities.

I appreciate the comments by the Chairman relative to Dr. Trujillo. We will certainly communicate the committee's concern and the committee's best wishes to Dr. Trujillo.

I think the Administration, and certainly the Indian Health Service, would like to express its strong support for the self-governance activities, the self-determination activities as expressed by tribal governments, both in terms of compacting under title 3 of the Indian Self-Determination and Education Assistance Act, and title 1 under that act. It is truly an expression of self-determination and self-governance by those tribes.

In addition I would like to point out, though, that as the agency proceeds with this demonstration project, the needs of all Indian tribes must be taken into account.

The Director of IHS on many occasions, in front of this committee and in national Indian meetings and in discussions that occur within the Department with the Secretary and Assistant Secretary for Health, has described and has shown his strong support for self-governance activities. The leadership of the Indian Health Service, those Area Directors and those Associate Directors, along with those of us who are on the immediate staff of the Director, have a clear understanding about what our obligations are relative to implementing this unique and innovative law. I believe there has been much progress made by the agency over the last 18 months as we have entered into a certain number of compacts and transferred functions and responsibilities and resources to self-governance tribes.

Indeed, it was only in October 1992 that the IHS was authorized to enter into compacts with tribes. That was under the amendments associated with the Indian Health Care Improvement Act. Last year, this Congress passed a law, Public Law 103–435, that extended this authority up to 18 years and requires an additional 30 tribes each fiscal year.

It was just 2 years ago this month that the IHS began its first compacting negotiations with tribes under this demonstration authority. Since then, the IHS has entered into 29 compacts, with 41 annual funding agreements, covering 225 tribes throughout this Nation. Obviously, given an all-Alaska compact, many of those tribal governments exist within the State of Alaska.

We have transferred functions and authorities and resources through these 29 compacts and these 41 AFAs with a dollar amount of $248 million in program services and $24 million in IHS funds associated with the transfer of nonresidual functions and activities and services from Area Offices and from our Headquarters here in Rockville, and in Albuquerque.

On April 18, the Director announced three key policy decisions that we believe, and I believe the tribes also, are in support, are critical to the continued implementation of the self-governance demonstration project. These three decision packages also have impact on title 1, the contracting that occurs under the Indian Self-Determination Act. These three decisions dealt with residual resources, user population as a factor in resource allocation, and resource allocation methodologies. There were 18 methodologies that were transmitted in these decision packages.

As we move through this fiscal year and as we move into fiscal year 1996, these decisions will be refined in consultation with tribal governments and the Administration so that the funding decisions and the baselines that are associated with that funding become more permanent and more firm.

I would like to just mention that the Residual Work Group was formed, and this particular work group had strong tribal leadership at the helm. The recommendations that have been made by this work group were joint recommendations from a mixture of the tribes that represented self-governance tribes, non-self-governance tribes, and those tribes who have chosen to have their services provided by the Federal Government, by the IHS.

The Director of the IHS made an initial decision that would call for a goal for the residual, being $15,560,000. That would represent the resources that Headquarters would need to carryout its residual functions at Headquarters. This is consistent with the recommendation that was made by this particular work group.

In addition, recommendations and decisions were made relative to user population and the Joint Allocation Methodology Work Group. Significantly, the Director of the IHS agreed with tribal governments relative to the methodology that would be used to allocate what are called "general pool funds" at Headquarters. The Director agreed to a methodology called the tribal size adjustment. We believe that this decision and this approach best defines a fairness for the basis of allocation of the Headquarters funds that have been pooled in a general way at Headquarters. This methodology bases 87 percent of the allocation of that general fund on population, and 13 percent on the total number of tribes. We believe this allocation methodology is consistent with the way the agency has made allocation decisions in the past.

These decisions also will be applied—to the extent that we can, given the law—to title 1 contracting tribes. We know that this committee and Indian country are concerned that we fairly distribute resources throughout the Nation. We believe that these decisions that have been made by the Indian Health Service and by our Director are equitable and are fair and will be applied throughout title 3 and title 1 and to direct tribes.

Mr. Chairman, I would like to go through a series of about four updates of issues that we know are important to the self-governance activities and important to the IHS, and certainly important to tribal governments as they pursue their activities under self-governance.

The first position that I would like to make the committee aware of is that just this past Friday, the announcement to fill the Director of our Office of Tribal Self-Governance has closed, so we will be proceeding over the next couple of weeks in having a panel prepared so that we can work together with tribes to interview those individuals who are qualified for the position. We have gone through a rather extensive process with tribal governments in the last advertisement for this position, and since a consensus was not reached relative to who the Director should be, the Director of the IHS decided to re-advertise the position.

In addition, there was a recommendation made previously that this position be upgraded to a senior executive service level. The

IHS and the Department of Health and Human Services has done that, and we have just completed the advertisement.

The second point that I would like to make is that the agency is, more than likely, not going to add additional self-governance tribes in fiscal year 1996. It is our position that we must take an adequate amount of time this year and next year to evaluate the impact of self-governance compacting on the agency and on those other tribes that have not been able to participate in the self-governance activities.

It is also our sense that we need to develop and put into policy systems and structures and processes that would allow us to better serve self-governance tribes; indeed, our Office of Tribal Self-Governance needs to be strengthened with the addition of staff. We have under consideration the establishment of a regional office somewhere in the northwest, perhaps in Seattle or Alaska, and the agency needs time to perform an adequate evaluation and assessment of the impact of self-governance activities on Indian health.

The third area that I would like to mention in summary, Mr. Chairman, is that the IHS is going under a certain amount of restructuring right now as it implements National Performance Review recommendations as we move toward implementing administrative cost reductions, as there is increased contracting under title 1, and as we have experienced compacting under title 3.

If I could give you three statistics, Mr. Chairman, that would reflect the direction in which the IHS is proceeding.

The first statistic is that over the last 1½ years the IHS Headquarters operation has reduced its FTEs by 16 percent. There are 117 less FTEs in the Headquarters operation than there were 14 or 18 months ago.

The second statistic, Mr. Chairman, is that at the area office level there has been a 22-percent reduction in FTEs at our area offices. This has resulted in a reduction of a little more than 600 administrative FTEs at the area offices. At the service unit level there has been an increase of 5 percent FTEs, amounting to a little over 600 increased FTEs at the service unit level. The priorities of the agency and the priorities of this Administration are clear, that we are reducing the size of the bureaucracy; we are reducing administration, while at the same time moving those resources for the delivery of services.

Mr. Chairman, I would like to mention very briefly a couple more items, and then I'll close.

The IHS is currently adopting a policy dealing with contract support costs. We have been working with self-governance tribes and non-self-governance tribes, and we have been working with our office of general counsel as we develop this policy. Currently we are preparing to send a policy out to Indian country for consultation because we believe this issue affects all tribes. We are developing a policy that would add contract support costs to tribal shares negotiated in fiscal years 1995 and 1996, consistent with the provisions of Public Law 93–638, as amended, and consistent with allowable cost principles. This policy will undergo significant consultation, and we believe that this is the proper way to proceed, given the potential impact of funding contract support costs and

adding contract support costs to qualified tribal shares at the area and at Headquarters.

Two more quick items, Mr. Chairman.

We have been contacted by a number of tribal governments—indeed, by staff on this committee—regarding alternative funding mechanisms to direct-fund Federal construction. I would like to point out, Mr. Chairman, that we do currently have what is called "joint venture demonstration program authorization," which we believe is compatible with the health facility priority system. That needs to be reviewed in a manner that would allow self-governance tribes and other tribes who are unable to participate in the Indian Health Service construction program, or adequately compete under that program—we believe this should be reviewed closely by the committee.

In addition, we believe that this committee might review the manner and the method by which capital leases are funded, thereby creating a guaranteed lease or payback option. We believe that this would spread the IHS initial outlay of cash over the life of the lease and permit the tribes to leverage private capital that would provide new and replacement facilities for tribes.

The third area that we would like to present for this committee's consideration, based upon staff inquiry from this committee and the committee's inquiry, is that we certainly need to review the establishment of a guaranteed loan program to improve access to private sector financing for all tribes. Loans could be repaid from IHS lease payments and our other 638 funds.

Mr. Chairman, I had the privilege of sitting in and listening to Secretary Cisneros testify in front of this committee relative to some of the innovative approaches that Housing and Urban Development is taking relative to financing capital construction on Indian land. We would be very interested in working with HUD and working with this committee to explore those possibilities for health facility construction.

Mr. Chairman, we believe this is a time when the agency must be in pursuit of increased efficiency and effectiveness and accountability and integrity, while maintaining a focus on the delivery of health care for Indian individuals, and at the same time maintaining this very special relationship that exists between tribal governments and the Federal Government. A quote from the Director's vision statement, I think, is appropriate with the proper context:

> Change must be accomplished so that our customer, the American Indian and Alaska Native patient, only notices improved quality of care. The needs of our patients and the communities are always paramount because they honor us when they come to us for care.

This is a fundamental principle by which the IHS operates. This is a fundamental principle and value of the Director of the IHS. When this principle and these words are placed within the context of a government-to-government relationship, with the IHS carryingout its responsibilities in partnership with tribal governments, this statement becomes especially meaningful.

Mr. Chairman, we are available to answer any questions the committee may have. Thank you, sir.

[Prepared statement of Mr. Lincoln appears in appendix.]

Senator CAMPBELL. Thank you. I have about 10 that I would like to submit to you and have you answer for this committee in writing, if you would.

Mr. LINCOLN. Yes, sir.

Senator CAMPBELL. Let me ask you just a few. You spoke pretty fast so I didn't get all of it, but you did say that you now have a search going on for a potential Director for the Office of Tribal Self-Governance?

Mr. LINCOLN. Mr. Chairman, as a matter of fact, we have completed the search, and the announcement ended this past Friday. So we are going through the process of identifying, of those applicants who applied, those that are qualified, and then we will co-jointly interview, with the self-governance tribes, those qualified applicants.

Senator CAMPBELL. When do you expect to have something ready?

Mr. LINCOLN. Mr. Chairman, generally it would take us about 1 week to 10 days to have Personnel complete its work. We would contact the self-governance tribes and schedule interviews of the individuals with the self-governance tribes and the IHS, and then if there was an agreement and a consensus and the Director agreed, we would send forward a name to the Secretary for the Secretary to make a selection. Because it is a senior executive service position, it requires a secretarial decision.

So I would anticipate that if we can come to an agreement as to who the recommendation would be to the Secretary, it would take approximately 1 month to 6 weeks after that time.

Senator CAMPBELL. You were a little vague. You did say that we needed systems to implement some of the self-governance activities. Heck, I already knew that, but I would like to know what steps you are taking to try to make sure that self-governance is an option for tribes. One of the problems that I think we've had is that some tribes simply don't have the infrastructure to be able to access some of the compacts that we want to give them.

Mr. LINCOLN. Mr. Chairman, if the committee would allow it, I would like Reuben Howard to answer that question.

Mr. HOWARD. In Mr. Lincoln's initial comments in regards to dealing on a government-to-government relationship, one of the major activities that we undertook just recently is the allocation of resources, approximately $64 million of a pool of $164 million, and developing a methodology that does actually help out some of those tribes that you are concerned about that do not have the infrastructure. That methodology is a methodology that deals with that issue in that it does address the issues of small tribes, for example, that may not have the infrastructure, but that some of these administrative dollars—their share would be higher so that they would be able to have that infrastructure.

Senator CAMPBELL. Okay.

You also mentioned, if I heard you right, that you have reduced the FTE—the bureaucracy FTE—by about 600, and increased the service FTE about the same amount. Reinvention and downsizing by the IHS—I guess we assume there are going to be some radical changes—can you give this committee some specific examples, as

you reduce the FTE that deals with the bureaucracy, some of the specific examples of things that have been reduced and changed?

Mr. LINCOLN. Mr. Chairman, the bureaucracy was reduced in two ways and at two locations. There was approximately a 117 FTE reduction at Headquarters, and those reductions primarily occurred as a result of attrition and the freezes that the agency has been under at Headquarters and at the area offices, and that's a reduction of people exercising early out and buyout under the provisions of that law.

Essentially, what has occurred is that as people exercise their right to leave the IHS, the agency has kind of absorbed the work within existing staff. The agency currently has what is called an Indian Health Design Team, IHDT, that the Director has organized. This team has met twice and will be meeting again this month. One of the responsibilities of this team is to guide the agency and identify goals and targets of the agency and, if you will, redesign the agency, so that as it reduces, that it is moving toward an identified new structure, that the creation of a new IHS is the responsibility of the IHDT.

I should mention, Mr. Chairman, that the Indian Health Design Team consists of about two-thirds to three-fourths Indian tribal members, and the remaining one-fourth is of IHS staff. So this is a tribally-driven effort.

The agency has experienced, as a result of these reductions—certainly at Headquarters—a difficulty in carryingout some of its administrative responsibilities. I believe those kinds of problems will be corrected as the Indian Health Design Team describes a new structure for the IHS to operate under.

The areas of reductions also need to occur, and some downsizing needs to occur, relative to the oversight and monitoring activities associated with Headquarters and area offices. The Indian Self-Determination Act and its amendments—not just title 3, but title 1 amendments—certainly fundamentally change our ability and responsibility to carryout detailed oversight of tribal contracts and tribal governments. Indeed, we are limited to one visit per year to a tribe in order to carryout our responsibilities of oversight, so that will fundamentally change the kind of staff that we keep at Headquarters and the kinds of roles and functions that they carryout.

There has been an additional reduction, Mr. Chairman, of over 600 FTEs at our 12 area offices, collectively a reduction of over 600. These reductions have primarily occurred within the program oversight areas. As an example, the number of people we used to oversee the dental program at a given area office would be reduced because we no longer carry those oversight responsibilities. In addition, some reductions have occurred within financial management and within contracts management, and those are consistent with National Performance Review goals.

Senator CAMPBELL. Okay. I thank you.

I would like to recognize the Vice Chairman, Senator Inouye.

Senator INOUYE. Thank you very much.

I just have one set of questions. I would like to submit the rest.

I believe last year the Congress passed an amendment that requires your agency to negotiate self-governance compacts?

Mr. LINCOLN. Yes, sir.

Senator INOUYE. And if I am correct, your testimony now indicates that you are not prepared to do so?

Mr. LINCOLN. Mr. Vice Chairman, that is correct. We believe that we must go through an assessment in this period. But in addition to that, Mr. Chairman, when we entered into an all-Alaska compact, we actually have included as a result of that all-Alaska compact 225 tribes in the self-governance demonstration project that is currently ongoing.

Senator INOUYE. What about those tribes that have completed the planning phase and are ready to negotiate? Will you give these tribes priority when you begin the process of negotiation?

Mr. LINCOLN. Mr. Vice Chairman, within the agency we have not discussed that question directly. What I can tell the committee is that we will raise that question with the Director. I believe we can provide the committee with a positive response, but I would want to be able to discuss the answer to that question with the Director of the Indian Health Service.

Senator INOUYE. When do you anticipate resuming the compacting process?

Mr. LINCOLN. We would resume the compacting process in fiscal year 1997.

Senator INOUYE. What is the real reason for this delay? Is it money, or policy?

Mr. LINCOLN. Mr. Vice Chairman, I believe there are two basic reasons. One of them is that the agency needs to assess the impact of compacting, not only on the agency but on Indian health care programs throughout the Nation. This assessment is especially critical when one considers the compounding effect of additional title 1 contracting and various reductions that this agency is going to have to take, but administratively and perhaps from a service standpoint.

The second reason is that indeed we do need to look at the resources that are available to support what is commonly called "tribal shares" at area offices and at Headquarters, and the agency needs the time to do a proper assessment relative to funding that could be made available. It needs to also implement those streamlining activities that would free up resources that would be available to all tribes, whether they are title 1 contracts or title 3 compacts.

Senator INOUYE. How often do you assess these compacts? It's been 8 years since we have had this law in effect, is that not right?

Mr. LINCOLN. Mr. Vice Chairman, the law has been in effect that long, but it has only been applied to the IHS for the last 2 years. We only have 18 months' worth of real experience in compacting. We were given the authority in 1992.

Senator INOUYE. Why this assessment? Are you having problems?

Mr. LINCOLN. Mr. Vice Chairman, we have had many inquiries from a variety of tribes, self-governance tribes, compacting tribes, and tribes who have exercised their rights under the Indian Self-Determination Act to not contract or compact. There are literally dozens and dozens of inquiries as to how the agency is allocating its resources and whether or not the interests of those noncompacting tribes are being addressed. The agency must dem-

onstrate—and I believe we can demonstrate—that we have allocated our resources fairly between compacting tribes and noncompacting tribes. But we must go through this effort now, and we must certainly show and demonstrate to all tribes that the agency's allocation principles are fair, and we need to do that.

Senator INOUYE. If I may followup a question that was asked by Senator Campbell in the FTEs, your agency makes up less than 2 percent of the total budget of the Department, is that not correct?

Mr. LINCOLN. That's not correct.

Senator INOUYE. It is 1.8 percent. But your FTE reduction represents about 13 percent of the reductions for the Department?

Mr. LINCOLN. Mr. Vice Chairman, the data that I have shows that the IHS in our fiscal year 1996 budget would absorb about a 1.5-percent FTE reduction. That is what our data shows.

Senator INOUYE. The Departmentwide reduction of FTEs numbers 1,766. Am I correct?

Mr. LINCOLN. Mr. Vice Chairman, I do not have those numbers in front of me. I do have some numbers——

Senator INOUYE. Well, the numbers I have received—it says for fiscal year 1996, it will be 1,766 FTE reduction Departmentwide, and 230 FTEs for your agency. That is 13 percent of the total.

Mr. LINCOLN. Okay.

Mr. Vice Chairman, if I could, I believe the agency would like to respond to that for the record.

Senator INOUYE. I would like to know why the discrepancy.

Mr. LINCOLN. Yes, sir.

[Information follows:]

The IHS has 6 percent of the discretionary dollars, and 25 percent of the FTE requested by the Department for FY 1996. The proposed FTE reduction of 230 for the agency in FY 1996 is 26 percent of the total reduction for the Department of 868 FTE, excluding SSA, however you are quite right in that the 230 FTE reduction would have represented 13 percent of the required 1766 FTE reduction had SSA not left the Department. When compared to FY 1993, which is the baseline to be used for determining compliance with the Federal Workforce Restructuring Act, a 1.5 percent FTE reduction is proposed for IHS, compared to a 4.6 percent reduction for the Public Health Service, a 4.9 percent reduction for the Department as a whole (excluding Social Security), and a 3.5 percent for the Department, if Social Security is included.

Senator INOUYE. I can understand 1.8 percent, and maybe doubling that, but to go up to 13 percent, that's pretty high.

Mr. LINCOLN. Yes, sir.

Senator INOUYE. I think someone's picking on you.

Thank you very much.

Mr. LINCOLN. Thank you, Mr. Chairman.

Senator CAMPBELL. Thank you, Mr. Lincoln.

The next panel will be Dale Risling, Chairman of the Hoopa Valley Indian Tribe, and Marge Anderson, Chief Executive of the Mille Lacs Band of Ojibwe from Onamia, MN.

Dale, you may proceed at your leisure.

STATEMENT OF DALE RISLING, CHAIRMAN, HOOPA VALLEY INDIAN TRIBE, HOOPA, CA

Mr. RISLING. Good morning. First I would like to thank the committee for its role in making self-governance a permanent authorization within the Department of the Interior.

The Hoopa Tribe is advancing at a steady pace under this new tribal-Federal relationship.

I am happy also to report that our Alternative Rural Community Hospital at Hoopa will be opening this year, in which self-governance played a major role.

Secretary Shalala and Dr. Trujillo have expressed their support for self-governance; however, there remains substantial opposition throughout the bureaucracy. This opposition is in the form of negative rumor and misinformation about self-governance to other tribes and Administration officials. A good example was mentioned this morning when it was suggested by Mr. Lincoln that an evaluation of the impact of self-governance on other tribes was going to take place in the IHS. This suggests that self-governance tribes are taking funds from other tribes, and this is not the case. There are plenty of safeguards to prevent that from happening.

These types of situation has created a major obstacles to the advancement of self-governance tribes. We ask for this committee's support by sending a strong message to the Administration with appropriate language, directing the Administration to honor the demonstration aspect and purpose of the self-governance demonstration project, that they work together with compacting tribes to help design and demonstrate to Congress, the administration, and tribes a new and better way of doing business between tribes and the U.S. This is, after all, the intent of Congress and participating tribes under this project.

It is important that it be understood and accepted by the Administration that each tribal compact will differ, depending on the tribe's capability, resources, and needs. Therefore, tribal independence, uniqueness, and flexibility must be respected and honored instead of bureaucratic attempts that are made to impose inflexible, nationalized standards and policies on compacting tribes.

The Office of Tribal Self-Governance must be elevated to the level of the Secretary of Health and Human Services. The office is currently located under the Director of IHS. It is unreasonable to think that fair and impartial negotiations can be accomplished when one party is a negotiator, and at the same time is charged with implementing the process and policies between the negotiating parties. It is also important that the office be elevated to the Secretary's office because it is likely that HHS will become the next Department to authorize all of its agencies to compact with tribes.

In regards to staffing of the Office of Tribal Self-Governance, we ask for support from this committee to end the delay in the hiring of a Director. We heard the report this morning about IHS getting close to making that appointment. We've been there before. We need assurance that this position is going to be filled. This delay has greatly impeded decisionmaking by IHS on essential policies and methodologies. As a result, self-governance negotiations have been stymied in some very, very important areas.

In terms of other staffing in the Office of Tribal Self-Governance, tribal consultation must be included in the hiring and organizational development to assure that only essential personnel are hired, and that another bureaucracy is not created.

I am also concerned that the IHS continues to utilize the Council of Area and Associate Directors, or CAAD, in the self-governance

negotiation process, without their role being clearly defined. Therefore I recommend that this committee direct IHS to revisit the CAAD charter, in consultation with the tribes.

Additionally, I recommend that the proposed IHS self-governance policy council not be established until IHS and tribes can mutually agree on its purpose and role in self-governance implementation, if any.

Self-governance was intended to be the process of restructuring the IHS. As tribes negotiated their share of IHS resources, the IHS was to reduce and restructure accordingly, including FTE reductions. The Clinton National Performance Review objective to streamline the bureaucracy and reduce FTEs has interfered with and complicated this one simple self-governance principle.

The Hoopa Tribe requests that this committee develop an approved language that will assure that any cost savings realized through current and future Federal streamlining be made permanently available to tribes for their respective budgets. The IHS should be directed to develop a self-governance restructuring plan, with tribal consultation, and to report to the tribes and to Congress on its progress on an ongoing basis. I believe that this should be done instead of implementing the assessment that they're doing on evaluating the impact of self-governance compacts on other tribes. I think that with proper restructuring and downsizing, that this will relieve criticism of compacting tribes impacting negatively on other tribes.

I question whether Administration policymakers Department-wide—budget personnel or OMB—really understand the treaty commitments, trust responsibility, and fundamental principles of self-determination and self-governance. If they do, then I would expect other health care agencies, such as the National Institute of Mental Health, the National Institute on Drug Abuse, and health resources which have traditionally been provided to States and cities would also be made available to tribes, as well as access to social services block grants, which we have been denied for the past decade.

The Hoopa Tribe opposes the concept of receiving block grants passed through State governments. Instead, we support block grant set-asides specifically for Indian tribes.

Finally, the Hoopa Valley Tribe strongly opposes the IHS fiscal year 1995 contract support cost draft policy and requests this committee to intervene. If enacted, this policy will have a devastating effect on tribal government operations. This draft policy is clearly contrary to the spirit and intent of Public Law 103–413, the Tribal Self-Governance Act of 1994.

I request that adequate funding for the Indian Self-Determination Fund, ISDF, be appropriated for the assumption of new and/or expanded health care programs. The current ISDF is inadequately funded at $7 million. The fiscal year 1995 estimated shortfall is $39 million.

In conclusion, I would like to thank you for this opportunity to share with you some of the Hoopa Tribe's concerns and experiences as a first tier IHS and Interior self-governance tribe.

Thank you.

[Prepared statement of Mr. Risling appears in appendix.]

Senator CAMPBELL. Marge, would you like to continue?

STATEMENT OF MARGE ANDERSON, CHIEF EXECUTIVE, MILLE LACS BAND OF OJIBWE, ONAMIA, MN, ACCOMPANIED BY DAN MILBRIDGE, HEALTH AND HUMAN SERVICES COMMISSIONER

Ms. ANDERSON. Thank you, Mr. Chairman and members of this committee. My name is Marge Anderson. I am the Chief Executive of the Mille Lacs Band of Ojibwe. I have with me Dan Milbridge, who is my Health and Human Services Commissioner. I will be brief.

I wish to make three points about Indian Health Service self-governance.

First, I know this committee always hears about bad health statistics of American Indians, that Indians have the highest rate of diabetes, tuberculosis, and fetal alcohol syndrome, that teen suicides among Indians are four times the national average.

There are no easy solutions to these problems. However, as tribal governments responsible for providing health care, self-governance has been that one ray of hope that we have had available to us to deal with these problems. But we will never be able to combat these statistics if the IHS insists on only providing us with 60 percent of what we negotiate for in our self-governance compact. It is not rational, it is not fair, it makes a mockery of our negotiations, and as tribal governments we should not be expected to accept only partial funding of our solemn self-governance agreements.

Further, as my written testimony details, we are very concerned that IHS will never fully fund contract support costs or ensure that shortfall funding is covered. Without full funding of our compacts, without our fair share of the Indian Health Service budget, it is becoming harder and harder to demonstrate that Indian Health Service self-governance can work. Unfortunately, it is my opinion that the bureaucrats want this project to fail. We must not allow that to happen, and we will continue to need this committee's help to make certain that tribal self-governance prevails.

Second, I thank the Chairman of this committee for his leadership on this issue, but I am sad to report that the Department is ignoring laws that you write. The IHS refuses to comply with the self-governance demonstration project which this committee extended last year; 30 new tribes per year were supposed to be allowed into IHS self-governance, but IHS is refusing to let new tribes in at all. I am very offended that all of your hard work is being ignored, and trust that you are equally offended and will take swift action to educate IHS about just what the law which you passed means.

Finally, what we really need is permanent self-governance legislation for Indian Health Service. The IHS will never take this program seriously as long as it is just a demonstration project. The committee should work with the Indian tribes to develop legislation as they did with the Interior Department. The IHS will be reluctant to assist in the development of such legislation. However, it is my belief that self-governance is the future of Federal Indian policy, and that bureaucrats who are trying to hold onto their jobs are preventing this policy from moving forward.

The only solution is for this committee to take swift and forceful action to make self-governance permanent in the IHS.

Thank you for this opportunity to testify. You and your staff have been our tribe's best friends in dealing with all of the aspects of self-governance. Dealing with bureaucrats can be extremely frustrating, and for the last several years you have always been there for us. In seeking passage of permanent legislation, we couldn't have asked for stronger, more direct support than that which we have received from you and your staff. You truly have championed this project, and for your devotion and dedication, the Mille Lacs Band of Ojibwe give you their sincere thanks.

[Prepared statement of Ms. Anderson appears in appendix.]

Senator WELLSTONE. Mr. Chairman?

Senator CAMPBELL. Yes, Senator Wellstone?

Senator WELLSTONE. With your indulgence could I just have a moment, first of all, to welcome Marge Anderson, the Chief Executive from my State of the Mille Lacs Band of Ojibwe Indians.

I wanted to apologize to Marge and the other panelists for coming in late. We have the hearing today of Dr. Henry Foster in Labor and Human Resources Committee, and he is about to testify. I wanted to let the Chief Executive know that I have a whole set of questions that I want to give to you and I want to talk to you about this and want to be as helpful as possible. As the Senator from Minnesota I warmly welcome you here today, and I thank you for your leadership.

Thank you, Mr. Chairman. I appreciate that.

Ms. ANDERSON. Thank you, Senator.

Senator CAMPBELL. Dale, in your oral testimony you said you favor elevating the self-governance negotiator to the Office of the Secretary. In the fiscal climate we face now, I personally think that's probably not going to happen. But would you care to expand on the problems you've experienced now that you think elevating it to the Secretary position would alleviate?

Mr. RISLING. We've done the same thing over in Interior as what I'm recommending here. On the Interior side we have put the Office of Self-Governance above the BIA, and that is so that it would be at a level where decisions can be made, where true negotiations can take place—more of a government-to-government type of relationship. It makes us feel a little bad when we go to the negotiating table and we're negotiating with messengers, and the decisions cannot be made. To us it sort of takes the sting out of the intent of self-governance, which—the way we look at it, it is more of a free, government-to-government type relationship. We should be dealing with policymakers.

The other thing is that I truly believe—and I think with this committee's support—that HHS is going to be the next department that we're going to be able to compact all of its agencies. So that would be the appropriate place to be, instead of moving this office up to the Secretary's office in a couple of years when we do get legislation to make self-governance permanent and all of its agencies compatible over there.

Senator CAMPBELL. We heard in earlier testimony that there was an increase of about 600 FTEs in the service area. In your Area

Office, while you have negotiated your share of this operation, have you noticed any specific effects of that?

Mr. RISLING. Regarding the FTE reductions? No.

Senator CAMPBELL. There was supposed to be an increase at the service area.

Mr. RISLING. There was, I think, a total of 20 positions eliminated in the California Area, but we haven't noticed any financial benefit as a result of that.

Senator CAMPBELL. Marge, in your testimony you cited a contract support funding problem. Perhaps you can tell us how many dollars you feel you have been short-changed by the recent IHS decision not to fund a contract.

Ms. ANDERSON. If I may, Senator, I will refer that to my Commissioner.

Senator CAMPBELL. Yes; and would you identify yourself for the record, please?

Mr. MILBRIDGE. My name is Dan Milbridge. I am the Commissioner of Health and Human Services for the Mille Lacs Band.

Contract support—this year they have proposed that it be part of our tribal share, that whatever our tribal share is, 80 percent of it will be considered program dollars, and the other 20 percent will be considered contract support costs. We feel that we should have 100 percent of our tribal share used for program, and the contract support costs paid on top of that.

Senator CAMPBELL. How much is that in dollar terms?

Mr. MILBRIDGE. I would have to refer to my compact, but it would probably be about $50,000 to $60,000.

Senator CAMPBELL. Okay.

Senator Inouye.

Senator INOUYE. Thank you very much, Mr. Chairman.

Throughout my membership on this committee, one word has been constantly used, but somehow misused and misinterpreted: "consultation." Now we find ourselves—last year—where the FTE reduction for Indian Health Service represented 47 percent of the whole Department's FTE reduction, and in fiscal year 1996 it appears that it may be 13 percent of the Department's FTE reduction, where the agency itself represents only 1.8 percent of the FTEs.

Have you ever been consulted on these reductions? Both of you?

Mr. RISLING. I have early on, over 1 year ago, in one meeting in Sacramento. There was an update given and a plan that was proposed, and it dealt with attrition and early retirement, mainly, and a few sort of temporary-type positions. So in our area there was really no higher level-type position eliminated.

Senator INOUYE. So what they did was to tell you, but they did not consult with you, or request your input in the reduction?

Mr. RISLING. That's correct, my input was never requested for that.

Senator INOUYE. Is that the same with you, ma'am?

Ms. ANDERSON. Yes; that is basically true, although the area office is—right now, the director of the area office is consulting with tribes right now. She is coming to our reservation on Friday to consult with us. They have downsized. I think the Headquarters should learn from the area offices on how the area offices do their downsizing.

Senator INOUYE. Now, the agency is suggesting that notwithstanding the mandate in our law, that they will not process compacts, and they wish to have an assessment. Have you been called upon to provide an input in this decision?

Mr. RISLING. No; we haven't, Senator. And as I mentioned before, the self-governance tribes are upset about this because it seems like we are being singled out. Other tribes that contract for programs and services are not being evaluated for their impact on other tribes. It seems like we're being singled out in this evaluation.

But no, we haven't been contacted or consulted with.

Senator INOUYE. Chief Anderson, the IHS has said they will not negotiate any new self-governance compacts in fiscal year 1996, and I gather you are prepared to do so. What sort of problems will you be facing as a result of this decision on the part of the service?

Ms. ANDERSON. Like Dale said, we haven't been consulted either on that, although we have some new tribes in our area who want to negotiate with the IHS. They have come to us for answers, and we don't know how to answer them because IHS is not going to compact with any new tribes this year.

Senator INOUYE. You spoke of the impact that non-self-governance tribes have been complaining about as a result of your involvement. What sort of impact do you think these non-self-governance tribes are talking about?

Mr. RISLING. Well, as you are aware, our annual funding agreement—goes out to every tribe in our area 90 days before it is signed off. In California there are some 100 tribes. So our budget goes out, and they take a look at the budget and they see basically a lump sum amount. They're assuming that we're getting more money than we should be getting.

Now, the first year that our annual funding agreement went out, it was challenged. It had to go through administrative appeal because tribes challenged it, and it was found that there was no negative impact that our budget had created on any of the tribes in the area.

The particular area, I mentioned in my testimony, where there is misinformation going out, self-governance tribes are constantly blamed for causing shortfalls to other tribes. A tribe may request funds for a certain thing and they are unable to get it, often the response from the IHS is, "Well, it's the impact of the compacting tribes." And that's not the case. There's no evidence anyplace where compacting tribes have had a negative impact. I believe that there is a committee within Indian Health Service that is set up specifically to review any negative impacts that the self governance annual funding agreements may cause. But as far as we know, there has never been a case where it has been proven that there is any negative impact. Tribes are very conscientious about this in the negotiating process.

Senator INOUYE. Thank you very much.

Yes, ma'am?

Ms. ANDERSON. Senator Inouye, the only negative impact that we hear from our areas is from newly-recognized tribes. We have three new federally-recognized tribes. Their funding is supposed to be coming from our tribal shares, but I think it's going to have an-

other negative impact on us. It should be a supplemental funding for those new tribes.

Senator INOUYE. Thank you very much.

Thank you, Mr. Chairman.

Senator CAMPBELL. I thank this panel.

The next panel will be Lindsey Manning, Chairman, Duck Valley Shoshone-Paiute Tribe; and Pamela Iron, Executive Director of Health Services of the Cherokee Nation in Tahlequah, OK.

Chairman Manning, before you start, how are you related to Claire Manning?

Mr. MANNING. Claire Manning is my cousin's sister. Her father and my father are brothers.

Senator CAMPBELL. She's doing a terrific job for the Native American Rights Fund in our State.

Mr. MANNING. Thank you very much. I will tell her.

Senator CAMPBELL. This is the last panel, and I would tell the panel that we're on a very short timeframe. All of your testimony will be included in the record, but if you can abbreviate your oral testimony, it would be appreciated.

STATEMENT OF LINDSEY MANNING, CHAIRMAN, DUCK VALLEY SHOSHONE-PAIUTE TRIBE, OWYHEE, NV

Mr. MANNING. I will be as brief as possible.

Thank you, Senator Campbell. I am very happy to be here today to have this opportunity to speak before the committee on the Self-Determination Act, which is the right Federal policy for tribes. Self-governance is true tribal management, but it's not for all tribes. Tribes must show their administrative capabilities to come into this program. The IHS still must maintain the coverage for those that choose not to.

Local control is more responsive to our needs. Over the last 3 or 4 decades Indian people have become educated and returned home to administer these programs. Some tribes no longer need excessive Federal coverage.

Self-governance has required the IHS to be specific in their functions, specific in their budgets, specific in their dollars, specific to break out tribal shares, specific in their area office distributions. It's a true budget breakout and shows accountability by the Indian Health Service. It requires the IHS to present actual operating costs at the area and Headquarters level, and that's been quite enlightening.

At the Headquarters level the Director has set a residual goal of $15.56 million. I was for a while on the Joint Tribal Methodologies Work Group, and we found out that the Assessment Line Item of the IHS of $33 million to $35 million is taken right off the top by the Public Health Service, and that money is not accounted for, not even to IHS. The Public Health Service—they are taking $33 million to $35 million out of our Indian money, out of the Indian Health Service money, to administer our money. So I think that needs to be looked into, and I request that special attention be directed to that accountability; $33 million is a lot of money and it can carry a lot of us through. The IHS, like self-governance tribes, I believe can be effective managers themselves of that money, so when it comes down to us it should reach us all the way.

At the Phoenix area office level, We have put the management of that under scrutiny. We found out that our service unit was allowed to operate at a deficit consistently, annually running into an $800,000 deficit. When the fiscal year ended it went back to the area office and they made an adjustment there, and it was off line. The next year you get to do it again. That's not real budgeting. Real budgeting is not presenting a budget and letting people overspend it. The actual operating cost is the budget that we're pursuing now, and I think what we're finding is that there was a pool of money there, discretionally being used to cover deficits. I think this exemplifies the CAAD that Chairman Risling from the Hoopa mentioned, the power that the CAAD carries forth.

I also agree with Chairman Risling on the complaint on the portrayal of self-governance being the catalyst for all the cuts coming to IHS. Our non-self-governance tribes need to be told clearly by Indian Health Service at all levels that the downsizing effort is the catalyst of a lot of our wrongs, besides the budget cuts that are coming in.

So at our area office meeting, self-governance tribes had to get up and defend themselves before the other tribes because we were being portrayed as the ones that were lessening their pool of funds.

As a small tribe, we initially supported this 30/70 formula, which meant more resources and more money to us. However, we can accept a tribal size adjustment formula. It means less money for us but I think it's a good middle ground that we would be willing to accept.

On contract support costs, the pool—the process that they use, they have a pool, and I think that it's distributed on a "first come, first served" is not a real good way to operate that. We need more money in there. Also reserving a percentage of tribal shares for contract support costs, I believe, needs to be looked at.

There are other concerns that are in my written testimony.

Deputy Director Lincoln mentioned that oversight is reduced to one visit a year to self-governance tribes. I think that is adequate. The new oversight that the tribes have to deal with on health care is from our tribal membership in their direct communication, right to our tribal council. If something is going wrong, they come to the council and the council can adjust it there, whereas before, when a complaint would come in, it would get lost in the system. There would be no accountability. When there was a complaint coming in, we got word that the then-Service Unit Director said, "Well, just don't pay any attention to it because in six months it will go away and there will be something else." So a lot of our complaints were going nowhere, but with self-governance, now with the tribal council ultimately responsible for it, we are now more responsive to the needs of our people. If it's dental or if it's mental health or something like, we can get right in there and do something about it.

I think what Senator Inouye said about 40 percent of the full Department FTE reductions last year were targeted for IHS again exemplifies too much Public Health Service control over the IHS. The IHS should be elevated at least equal to the Public Health Service. That may be excessive oversight.

Finally, I cannot accept without objection all Indian agencies being cut at this time. The Chairwoman of Mille Lacs mentioned

that new tribes are being recognized every day, and we're all drinking from the same trough, so we need to enhance our programs and build them.

I would like to thank you.

[Prepared statement of Mr. Manning appears in appendix.]

Senator CAMPBELL. Ms. Iron, go ahead. You may proceed.

STATEMENT OF PAMELA IRON, EXECUTIVE DIRECTOR, HEALTH SERVICES, CHEROKEE NATION, TAHLEQUAH, OK, ACCOMPANIED BY CHARLES L. HEAD, SELF-GOVERNANCE COORDINATOR

Ms. IRON. Mr. Chairman and members of the committee, I bring greetings from Chief Wilma Mankiller, the Principal Chief of the Cherokee Nation. It is an honor to be able to testify on her behalf and to represent the 160,000 tribal members and 95,000 active users in our health care delivery system.

Almost no other issue is of greater importance to the Cherokee Nation than Indian health care delivery and proper implementation of our self-governance compacts. We are the largest tribe that entered into the compact in both the Interior in 1990, and into the DHHS in 1993.

As an example of how self-governance is being implemented by the Cherokee Nation, I would point to the Cherokee Rural Health Network. Our health network is the first tribal health network established in the United States, utilizing managed care concepts in redesigning our health care delivery system. The Wilma P. Mankiller Health Center is a new 35,000 outpatient facility dedicated on April 29, 1995. This is an important component of our network. We want to thank this committee, and especially Senator Nickles for his assistance in obtaining the funding and naming of this facility.

The decision of Congress to amend the Indian Self-Determination and Education Assistance Act by adding the Self-Governance Demonstration Project Act was a crucial step in strengthening the government-to-government relationship between the United States and the Cherokee Nation.

We feel that there are still some people at all levels of IHS who do not take the program seriously because it is not a permanent part of the agency. This attitude at times results in a lack of cooperation in the implementation of the health programs assumed by the Cherokee Nation. We believe that self-governance within the IHS has been a demonstration project long enough. Permanent implementation of the IHS self-governance program should be a high priority of the Federal Government. Chief Mankiller and the Cherokee Nation are grateful to the Chairman, to Senator Inouye, and the committee for your dedication to this program, and we will do everything we can to persuade the Clinton administration to support prompt enactment of permanent legislation.

Critical to the successful continuation of Indian health care delivery to the IHS self-governance program is retention of proper funding allocation formulas. The IHS Director announced adoption of a new allocation formula called the "tribal size adjustment formula," rather than the historical formula based on active user population, recently. Shifting to this new formula will divert Central Office

funding from tribes with IHS user populations of more than 1,500 to those with fewer than 1,500 users. The proposed new formula would benefit only 4 percent of the IHS users in Oklahoma and cause adverse impact on 96 percent of the users. Nationally, the new formula would result in 90 percent of the IHS users receiving less funding for their tribes. We have a tribal size adjustment versus the 100 percent user formula comparison here. We had a larger chart that didn't quite find its way up here yet that shows this adverse impact.

Analysis shows that 89.73 percent of users would receive more resources using a 100-percent active user formula. Any extra funding to make up for small size would not be necessary funding; it would be extra funding.

We encourage not taking money from users and shifting it to bureaucracies. The use of this method or any similar method for determining tribal shares would result in a radical reallocation of IHS funds away from eligible users who are members of large tribes, such as Navajo and the Cherokee Nation, and toward support of bureaucracies of certain tribes.

We encourage you to think about this, to make all eligible Indians more healthy, not their tribal bureaucracies. Furthermore, the Cherokee Nation is emphatic that any funding allocation formula for any program for Native Americans—block grant or otherwise—must be justified and based on active user population served by the program.

Here we wish to express our sincere appreciation to the Chairman and the committee for their successful effort to restore IHS funding in the 1995 budget. Now it is all the more important to remind the Appropriations Committee that the unmet need for IHS remains at approximately 30 percent of the funds required. With this enormous unmet need, there should be no reductions in overall Indian health care funding. We encourage full funding of contract health care. This is particularly essential. It remains a mystery why, in Oklahoma, that we continue to have large contract health care denials, and we do not receive any distribution of the funds from the Central Office.

We would greatly appreciate strong support for IHS fundings from members of this committee, especially Senators Gorton, Domenici, and Reid, who also serve on the Senate Interior Appropriations Subcommittee.

Looking at the FTE reductions, we propose that FTEs working directly for tribes through IPAs and MOAs be allocated to a tribal FTE pool and be free from all FTE reductions or ceilings, especially since costs for salaries for these positions were covered by the operational funds provided to tribes. The Cherokee Nation has 750 tribal health employees, and of those, we have 27 IPAs or MOAs. Those salaries are paid by our operational funds, so it does not impact on the Federal direct delivery FTEs.

Finally, the Office of General Counsel opinion contended that the level of Federal oversight necessary for construction of Federal facilities is inconsistent with the Self-Governance Demonstration Project Act's goals. This opinion leads to the absurd result that tribes can perform these services under title 1, but not under title 3. The Cherokee Nation has constructed facilities; we constructed

the Redbird Smith facility and new Wilma P. Mankiller Health Center. We also are in construction phase I for a new Salina Health Center, and we have done this through construction contracts. We feel that it is important that this be in permanent legislation.

In conclusion I would like to thank this committee for the close working relationship that the Cherokee Nation has had. We urge you to implement self-governance on a permanent basis.

[Prepared statement of Ms. Iron appears in appendix.]

Senator CAMPBELL. Thank you, Ms. Iron.

We have about four or five questions, but because of time constraints I am going to have staff submit those to you. If you would answer those in writing for the committee, I would appreciate it.

Also, just let me reaffirm—I think I can speak on behalf of the vast majority of the members on this committee, that you can look forward to continued support and sensitivity to the problems that Indian tribes face as they are trying to move toward self-governance. You've always had a sensitive ear in here. Even though we are severely restricted because of the fiscal constraints that we have, this committee knows full well that Indian people have every right to expect full funding for the programs that are so important to their survival.

In any event, the hearing record will stay open for two additional weeks if anyone in the audience or any people at home wish to submit testimony in writing. Please have them do so in about the next 14 days.

With that, this hearing is adjourned.

[Whereupon, at 10:44 a.m., the committee adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF LINDSEY W. MANNING, CHAIRMAN, SHOSHONE-PAIUTE TRIBES OF THE DUCK VALLEY RESERVATION

Mr. Chairman and members of the committee, I am Lindsey Manning, Chairman of the Shoshone-Paiute Tribes of the Duck Valley Indian Reservation.

Our homeland is half in Idaho and half in Nevada. We properly refer to our location as that Nevada and Idaho skirt our borders. Our reservation is 290,000 acres, all of which is tribal land. Our tribal headquarters is located at Owyhee, Nevada. We have approximately 1,800 enrolled members with about 1,200 members residing on our reservation. Our main industry stems from our land base and involves ranching, farming, and outdoor activities.

The Shoshone-Paiute Tribes are served by the IHS Phoenix Area Office and are the furthest from the Area Office—approximately 600 miles. We are presently in a multi-tribal service unit which serves five tribal governments. The Owyhee Service Unit includes the only IHS hospital (a 15-bed inpatient facility) in Nevada and Idaho, and two outpatient clinics at Elko and Ely, Nevada. Because of our isolated location, the hospital and clinic at Owyhee provide services primarily to the Duck Valley Tribes as well as the non-Indians in the region. The clinics at Elko and Ely primarily serve the other service unit tribes with inpatient and specialty care being provided to the other tribes at local non-IHS health care facilities through Contract Health Care funding.

As the most remote service unit served by the IHS Phoenix Area Office, the hospital and clinic at Owyhee has suffered from poor management which has resulted in a lack of continuity of care for our people. In 1988, the Phoenix Area Office attempted to close inpatient services at Owyhee and reduce emergency service coverage. Based on our isolation and health care needs, and with the assistance of the Appropriations Committees, we were able to keep the hospital open. Shortly thereafter, the tribes received a grant from the IHS to conduct a full utilization study of the Owyhee hospital and clinic. This preliminary feasibility study indicated that the facility could be operated efficiently by the Tribes and provide improved health care if actual operating costs are made available to the tribes. Today, plans are underway to do just that.

In 1991, the tribes entered into a Self-Governance agreement with the Department of the Interior. We entered into an Indian Health Service Compact of Self-Governance effective January 1, 1995. Our first IHS Annual Funding Agreement included our community health programs. Recently we amended our Annual Funding Agreement to add the facility's Contract Health Care program. For fiscal year 1996, we will include all remaining outpatient and inpatient services provided at Owyhee.

Self-Governance has given our tribes control of our local programs and allowed us to be more responsive to the health needs of our population. We have cut through layers of needless and repetitive federal processes and clearances and made more resources available at the service delivery level. In addition, the planning resources made available to us enabled us to improve our tribal administrative capacity. Our tribes' views on specific issues follows.

IHS Office of Tribal Self-Governance. The IHS Office of Tribal Self-Governance (OTSG) has been and continues to be very involved in and supportive of our negotiations. However, the OTSG has never been adequately staffed to negotiate agreements and assist tribes with implementation of our agreements. Lack of adequate staffing has contributed to the delay in distribution of funds due to be transferred to us in early January under the terms of our funding agreement. We support elevation of the Office of Self-Governance to the Department level and believe the office must be adequately staffed to distribute funds in a timely manner and to assist with implementation of tribes' funding agreements.

Residual and Tribal Shares. Under Self-Governance, all IHS functions and resources are designated as either "residual" or "tribal shares". True "residual" resources are those used to conduct Indian health functions required by law to be carried out by Federal employees as inherently federal functions. All other resources of the IHS are "tribal shares" meaning they are available to be transferred into a tribe's Annual Funding Agreement if the tribe chooses to take responsibility for the corresponding function. Tribal shares which a tribe elects to leave with the IHS have been designated "retained tribal shares" and may be transferred to the tribe at a later date if the tribe so chooses. Designating a resource a tribal share in essence gives tribes discretion over whether to take responsibility for that function and resource or to leave responsibility with the IHS.

Under the Director's April 18, 1995 decision, a residual "goal" is established for Headquarters, and each Area Office residual is to be determined separately with the participation of the tribes served by that Area Office. However, neither the decision on a Headquarters residual amount nor our Area Office's process for determining a residual amount has ever provided for consistent and meaningful tribal participation. The determination of residual and tribal share resources must be arrived at only after full participation of all tribes, and discussion and negotiation over which party can best carry out particular functions or activities.

In addition, of the amounts identified as residual, the IHS has not provided descriptions of the functions and services being provided with those resources. Without a clear understanding of the functions being carried out by the IHS with residual resources, the IHS' and Tribes' respective responsibilities are never clear.

Allocation Methodologies for Tribal Shares. As our tribes establish the outpatient and inpatient programs at Owyhee as an independent operating unit in fiscal year 1996, the administrative costs for these programs will be transferred from IHS Headquarters and the Phoenix Area Office to our Tribes' administration. As a relatively small tribe, our administrative costs to operate these programs will not necessarily be met by our Area and Headquarters tribal shares from similar functions. In addition, as we establish an independent operating unit serving primarily our tribes and non-Indian community residents, we will lose economies of scale for some services which previously benefited more than the Duck Valley Tribes. With this in mind, for Area and Headquarters resources which have previously not been made available to tribes, our Tribes support an allocation methodology that will provide us an adequate administrative base and allow us to maintain the broadest array of services possible.

As a relatively small tribe, the "30/70" formula—under which 30% of the tribal share resources are allocated among tribes based on the total number of tribes and 70% are allocated based on the number of active users—would be most beneficial to our tribes. The "tribal size adjustment" formula also provides a base for small tribes with the base decreasing as population size increases. As compared to the "30/70" formula and the "100% active user" formula, under which funds are distributed based solely upon the population served, the tribal size adjustment formula is an acceptable compromise for our tribes. We have supported the use of this formula for allocating Headquarters General Pool funds with the understanding that it is a compromise for us and that it is aimed at equitably allocating resources taking into account the relatively higher administrative costs for smaller programs.

Contract Support Costs. The contract support funding provisions of the Indian Self-Determination Act provide for full funding of tribal administrative costs. These provisions also ensure that contract support funds will not duplicate program funds, and provide a reporting mechanism through which the IHS is required to report any deficiency in funding for such costs. Existing IHS policy for administering contract support funds, however, does not address contract support needs associated with tribal share resources that are made available to tribes under Self-Governance and the recent amendments to Title I of the Act in Public Law 103–413.

IHS' current proposal to reserve a percentage of tribal shares from which to fund additional contract support cost needs associated with tribal shares does not reflect the recommendations of tribal participants and will perpetuate incomplete and inaccurate reporting of true contract support needs. The IHS proposal reflects an arbi-

trary percentage which is not supported by an analysis of the resources in Area and Headquarter's tribal shares. We request full tribal participation in development of a process under which a tribe's full contract support need is based on an analysis of its actual program and administrative costs, and that need is funded annually on a recurring basis (with any deficiency in funding reported to Congress).

Shortfall and Full Funding of Tribal Shares. In the Director's April 18, 1995 decision on residual, $15.56 million is identified as a "goal", with the caveat that as more tribes elect to compact and contract, it may be necessary to look at the transitional amounts required to provide services to all tribes. The initial federal policy behind the Indian Self-Determination Act envisioned a clear cut transfer of resources from the Federal government to the tribes as tribes chose to take responsibility for local programs. This vision was never implemented under Title I, and resulted in an increased Federal bureaucracy and justified but escalating contract support costs on the tribes' part.

Now, shortfall funds have been provided under Self-Governance to fund transitional costs associated with the transfer of resources to compacting tribes to avoid reducing or limiting services to other tribes as tribal shares are taken out of programs or other activities serving multiple tribes. The IHS must develop a specific and immediate strategy for reducing staff and other resource requirements which parallels increases in the level of compacting and contracting by tribes so that shortfall funds are not relied on in subsequent years to meet "transitional" needs. The IHS must be able to track by program or other activity increases in compacting and contracting and the resulting portion of the program or activity which the IHS continues to operate. Unless federal reductions approximately parallel increases in compacting, stable base funding with recurring funds cannot be achieved. Full funding of tribal shares and the development of stable base funding has been a goal of Self-Governance, and is necessary to ensure the long term stability and success of tribal health programs.

Trust Responsibility and Appropriations for Indian Health. All of the foregoing issues involve allocating resources appropriated to improve Indian health. As tribes take on increasing responsibilities for community services, we must not lose sight of the Federal Government's ongoing responsibility to tribes which is a result of tribes' unique political status as sovereign governments. President Nixon, in his initial vision for Indian Self-Determination, expressed this ongoing responsibility to Indian tribes as follows:

The special relationship between Indians and the Federal Government is the result ... of solemn obligations which have been entered into by the U.S. Government. Down through the years, through written treaties and through formal and informal agreements, our government has made specific commitments to the Indian people. For their part, the Indians have often surrendered claims to vast tracts of land and have accepted life on government reservations. In exchange, the government has agreed to provide community services such as health, education and public safety, services which would presumably allow Indian communities to enjoy a standard of living comparable to other Americans.

All Congressional actions related to Self-Governance and annual appropriations for Indian health must be made in light of tribes' unique political status and the government's trust responsibility to tribes.

We must keep in mind the diverse needs of tribal government, ranging from day to day operation of community programs to tribal-federal partnerships. The Administration must reconsider subjecting IHS and BIA service programs to FTE reductions. As tribes take more responsibility for local programs, we need professional expertise entering rather than leaving our programs. At a minimum, savings from FTE reductions from our programs must be returned to local service delivery programs. Last, restructuring and downsizing of Federal Indian programs must involve meaningful consultation and participation of all tribal governments. Self-Governance provides a model for this dialogue and participation.

Thank you for the opportunity to present my views on IHS's implementation of Self-Governance.

SHOSHONE-PAIUTE TRIBE
DUCK VALLEY RESERVATION
Owyhee, NV, July 13, 1995.

Hon. JOHN MCCAIN,
Hon. DANIEL K. INOUYE,
U.S. Senate,
Washington, DC.

Dear Senators McCain and Inouye: Thank you for your letter of May 5, 1995. My sincere apologies for this delayed response to your inquiries.

Question: Do you think Congress should step in and define by statute, what is and what is not an allowable residual?

Answer: At this time it is our opinion that it is premature to legislate the definition of residual. While it is presently true that IHS has not provided an extensive definition of residual functions or what the tribes can rely upon with IHS retained funding, the IHS has committed to working jointly with Tribes to address the residual issue. We believe that Congress should allow this process to work. Perhaps a suggestion could be that IHS be compelled to engage in this process by the Committee.

Question: Would you please cite some examples of why administrative costs are higher for your Tribe than for other Tribes nearer metropolitan areas or with larger service population?

Answer: A key factor is isolation. Recruitment of capable administrators at a "lower than scale" pay rate fosters the need to offer an above average salary. Added insurance coverage and fringe benefits are required to fill vital positions. Outdated equipment (i.e. computers and telecommunication links), cost of delivery, telephone services, express mail delivery to hubs, transportation, advertisements, adequate and attractive housing acquisitions must be built into the isolated reservation administrative costs.

Thank you again for allowing our input. Should further clarification be desired, please notify me.

Sincerely,

LINDSEY MANNING, *Chairman.*

PREPARED STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S SENATOR FROM COLORADO

Thank you Mr. Chairman. I want to thank you for conducting this important hearing on the implementation of the Tribal Self-Governance Act by the Indian Health Service.

What started as a demonstration project that was designed to improve and strengthen tribal control over Federal funding and program management, has now become a permanent program that gives tribal governments the authority to negotiate for the management of many programs in the Department of the Interior and the Indian Health Service.

I know my interest in the implementation of the Self-Governance program is shared by all members of this committee, because it is a program that is innovative, and is a cornerstone in bringing federal resources directly to tribes. The process, however, of bringing greater tribal participation in the Self-Governance program will take considerable time and many tribes, due to unique circumstances, may not elect to participate in the Self-Governance program.

As a result, the question that remains is how will the responsible agencies continue the implementation of the Self-Governance program while continuing to serve non-participating tribes. This type of question was recently asked of me by the Chairman of the Ute Mountain Ute Tribe, in my home State of Colorado, and is continuing concern.

Mr. Chairman, I will continue to follow this program with great interest and look forward to the testimony to be presented today.

MILLE LACS BAND OF CHIPPEWA INDIANS
Ne-la-Shing Clinic

WRITTEN TESTIMONY ON:

THE INDIAN HEALTH SERVICE SELF-GOVERNANCE PROJECT

AS SUBMITTED BY:

THE HONORABLE MARGE ANDERSON, CHIEF EXECUTIVE
MILLE LACS BAND OF OJIBWE INDIANS

to the
Committee on Indian Affairs,
U.S. Senate

May 2, 1995

Mr. Chairman and Members of the Committee, my name is Marge Anderson, and I am Chief Executive of the Mille Lacs Band of Ojibwe Indians.

The Mille Lacs Band of Ojibwe Indians was one of the first Tribes in the nation to negotiate and sign a Self-Governance Compact and Annual Funding Agreement with the Indian Health Service (IHS). For background purposes, the Band became a participant Tribe in the Department of Interior Self-Governance program during the demonstration period in 1989, and knew that Self-Governance could be successfully implemented within the Indian Health Service. When the Congress extended Self-Governance to IHS in 1992, the Band seized the opportunity to negotiate a Self-Governance compact with IHS largely because of our frustration with receiving directives from IHS on how funds allocated by the Congress for Tribal health needs must be spent on our own reservation.

I will focus this testimony on the key items which directly impact the funds available to Self-Governance Compact Tribes to support their health care delivery system. The first two items, however, are extremely critical and we ask that they be given the Committee's closest attention.

(1) Fully Fund Contract Support Costs

Although the [illegible] amount of funds [illegible] reason to believe that [illegible] tribes will need [illegible] know, the IHS's [illegible]

does there exist reason to believe that the amount of contract support dollars actually available to any particular compact Tribe, and the Mille Lacs Band in particular, will adequately cover our negotiated funding agreements. Additionally, it is anticipated that the Director of IHS will take the position that no contract support funds will be paid on negotiated Tribal shares for F.Y. 95, nor will it be paid for all subsequent years. We need the Congress to direct IHS to ensure that contract support costs are fully funded for F.Y. 1996.

(2) Ensure that Shortfall Funding is Fully Covered in F.Y. 1996 Compacts.

The issue of shortfall funding directly affects our health care delivery system. Shortfall funds are directed to cover the gap between the negotiated Tribal share of the IHS budget line items and the amount of money available within IHS to cover that share. Mille Lacs was able to obtain its full funding amount to cover our F.Y. 95 Compact, but there is not guarantee that those funds will continue to be available in the future. IHS projects a shortfall in F.Y.'95 Annual Funding Agreements of $6-8 million dollars. We know of no one who has yet determined how the IHS calculated the amount of shortfall funds needed for the upcoming fiscal year as presented in the F.Y. 96 budget request, nor has anyone determined if that amount will in fact cover each Compact Tribe's total demonstrated need.

These two issues dealing with contract Support Costs and Shortfall Funding are extremely critical to the success of Self-Governance Tribes. Together, these funding areas provide to the Band the financial support necessary to deliver health care which IHS would otherwise be required to provide through its legal trust responsibility. Self-Governance was intentionally designed by the Congress and the tribes to ensure that we, as a Self-Goverance Tribe, have the tools to address our own program priorities and develop more local, flexible solutions to the health care problems unique to our tribal population. The IHS does not appear, however, to share with the Congress its commitment to allow Tribes to determine their own health priorities and to allocate our resources accordingly.

You should be aware that from the beginning, Tribes pursuing compacts with the IHS have had to deal with a budget which has never adequately met the health needs of Indian people. In F.Y. 1995, per capita spending on Indian health care was approximately $1,200 -- less than one half of the national average per capita amount spent on medical services. The picture has not significantly improved in F.Y. 1996. In fact, the President would have to double his current budget request for the IHS in order for the Indian health care delivery system to be on equal par with the United States as a whole.

Given the current federal budgetary constraints, we realize that doubling the IHS budget may not be realistic, although we remind the Committee that the federal government has a unique legal responsibility to ensure that Indian health care needs are met. In this context, we urge you to consider that Self-Governance Tribes have the responsibility to provide the same level of servicess to our people as IHS provides -- the difference is that we are expected to perform these services with less resources than IHS, because of IHS's refusal to adequately address budget needs and fully fund compacts. This is proven by the fact that IHS did not request funding for population growth. Further, IHS has made no effort to reduce personnel levels, in spite of the fact that for each of the last four years, the Congress has clearly required personnel reduction as Self-Governance Compacts are signed and responsibilities transferred to the tribes.

(3) IHS Should Allow Compact Tribes to Base Their Funding on Actual Service Costs to Indian Patients, Rather that Using the "User Population" as Defined by IHS.

The issue of user population continually plagues the Mille Lacs Band of Ojibwe in its self-governance negotiations with IHS. User population is derived from the number of eligible Indians living within a specifed geographic area in relationship to the reservation boundaries. The data base system employed by the IHS to determine the number of "users" grossly undercounts the number served by the Tribe. A critical by-product of user population is the term "active users" -- eligible Indians who have been provided a service within the last three years. Mille Lacs serves every eligible Indian who presents themselves for health care services, in accordance with the intent of the Congress. However, it is impossible to predict the numbers of such patients in advance or the cost of their treatment.

IHS has historically refused to permit a Tribe to base its funding needs on its actual service costs for all Indian patients serviced. Mille Lacs is required to absorb the cost, which adversely affects our ability to provide necessary care to our service population. Therefore, we ask that the Committee direct the IHS to fund tribes based on actual service costs to Indian patients.

I know this Committee always hears about the bad health statistics of American Indians. That Indians have the highest rates of diabetes, tuberculosis, and fetal alcohol syndrome. That teen suicides among Indians are four times the national average. There are no easy solutions to these problems. However, as a tribal government responsible for providing health care, self-governance has been the one ray of hope we have had available to us to deal

with these problems. But we will never be able to combat these statistics if IHS insists on only providing us with 60% of what we negotiate for our self-governance compacts. It is not rational, it is not fair, it makes a mockery of our negotiations, and as tribal governments we should not be expected to accept only partial funding of our solemn self-governance agreements. Further, as my written testimony details, we are very concerned that IHS will never fully fund contract support costs or ensure that shortfall funding is fully covered. Without full funding of our compacts -- without our fair tribal share of the IHS budget -- it is becoming harder and harder to demonstrate that IHS self-governance can work. Unfortunately, it is my opinion that the bureaucrats want this project to fail. We must not allow that to happen, and we will continue to need the Committee's help to make certain that tribal self-governance prevails.

I thank the Chairman of the Committee for his leadership on this issue, but I am sad to report that the Department is ignoring the laws that you write. The IHS refuses to comply with the Self-Governance Demonstration Project which this Committee extended last year. Thirty new tribes per year were supposed to be allowed into IHS Self-Governance. The IHS is refusing to let new tribes in at all. I am very offended that all of your hard work is being ignored, and trust that you are equally offended and will take swift action to educate the IHS about just what the law which you passed means.

(4) The Mille Lacs Band Requests that the Congress Provide Supplemental Funding to Area Offices for New Tribes.

I would like to point out that three new Tribes within the Bemidji area have recently gained recognition as federally recognized tribes. The funding for the additional Tribes to provide health care to their people, however, is being taken out of the Bemidji area pot of funding, which was already minuscule prior to the addition of the new Tribes. The funding of these new tribes from our existing Bemidji Area funding will obviously have an adverse impact on all of the tribes within the Bemidji Area, and must not be allowed. Since the Congress has taken on the responsibility of legislatively recognizing three new tribes, it must also face its responsibility to find funding for them without negatively impacting the rest of us, who reside in the most underfunded Area nationwide.

(5) The Congess Should Mandate that the IHS Provide Stable Base Funding to Self-Governance Compact Tribes.

Once again, the IHS budget request does not include any commitment to providing Self-Governance Compact Tribes with a stable base of funding. There is certainly no requirement that permanent legislation be enacted before such a mandate may be issued. As an example, the BIA was under a mandate to proved stable

base funding under the Demonstration Project phase of Self-Governance. The institution of stable funding bases has made annual funding agreement negotiations much easier, and the IHS should be forced to implement the same stable base funding. For the Tribes, having a stable funding base permits the development of longer range planning, rather than being forced to scramble each year to devise program adjustments based on each year's available funding. Without such a mandate, IHS lacks commitment to provide funds at any particular level. We urge that you direct the IHS to implement stable base funding.

Conclusion: Make Self-Governance Permanent within the IHS.

All of the directives which I have requested would be helpful in moving self-governance along within the Indian Health Service. However, nothing would push the bureaucrats faster than legislation making self-governance permanent in the IHS. Until it is permanent, IHS will continue to use the old excuse that as a "demonstration", the agency cannot take permanent actions to reorganize and restructure. Eventhough during the 103rd Congress you extended the project for another 18 years -- which makes the project essentially permanent -- I strongly believe that we need legislation which will leave no doubt that Self-Governance is here to stay.

Thank you for this opportunity to testify. You and your staff have been our tribe's best friends in dealing with all of the aspects of self-governance. Dealing with bureaucrats can be extremely frustrating, and for the last several years, you have always been there for us. In seeking passage of permanent legislation, we couldn't have asked for stronger, more direct support than that which we received from you and your staff. You have truly championed this project, Chairman McCain, and for your devotion and dedication, the Mille Lacs Band of Ojibwe sincerely thanks you.

MILLE LACS BAND OF CHIPPEWA INDIANS
Executive Branch of Tribal Government

May 18, 1995

Chairman John McCain
Committee on Indian Affairs
Washington, D.C. 20510-8450

Dear Senator McCain:

It was an honor to testify before the Senate Committee on Indian Affairs on Indian Health Service Self-Governance. As you are aware, the Mille Lacs Band of Ojibwe was a first tier tribe in both self-governance arenas: Indian Health Services (IHS) and Bureau of Indian Affairs (BIA). It is with eternal frustration that we must come back to this Committee year after year to report on how IHS continues to ignore the laws you write. We sincerely appreciate the interest and dedication of the Committee to self-governance, and appreciate this opportunity to answer your question for the official hearing record.

Answer 1. You asked what our indirect cost rate is and the amount of shortfall that we anticipate to absorb a result of the recent IHS decision not to fund contract support costs associated with our Area and Headquarters tribal shares. Our indirect cost rate for FY 1996 is anticipated to be approximately 17%. We do not currently have that rate approved and we can only assume that it will be similar to our FY 1995 indirect cost rate of 17.1%. Since we are not sure what our tribal shares will be for FY 1996, I will base our estimated shortfall on last year's Annual Funding Agreement. Our anticipated shortfall can be computed by adding $231,005 (FY 1995 Area Share) and $168,060 (HDQTR Share) and multiplying their sum of $399,110 by 17% to arrive at an estimated shortfall of **$67,848**. This figure, however, does not consider the tribal shares of the unresolved issues that have been promised our tribe by the IHS.

Answer 2. You asked me to provide you with more detail on the concept of allocating tribal share funding based on actual service costs to tribes. The IHS data system has historically been filled with inaccurate data that is antiquated by the time it becomes official to the IHS; usually two to three years after compilation by the tribe. Our proposal suggests that each tribe be guaranteed a stable base which only fluctuates

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with congressional action, ie., an increase or reduction in the federal budget would proportionately effect each compact based on the same percentage. The alternative proposal is that the funds allocated for Indian health care in Indian country should follow the users of the Indian health care systems. Many tribal health care facilities that get minimal utilization are funded at the same level as tribal health care facilities generating maximum utilization. Once we have reached our threshhold of expending our limited health care resources on our IHS-defined population, we lack funding to provide services to those needing health care services. Those facilities that never reach their threshhold ultimately end up with surplus funding. In essence, some type of work load factor needs to be calculated into the funding distribution formulas.

I hope that I provided adequate answers to your questions regarding IHS self-governance. I sincerely hope the opportunity to provide additional comments for the hearing record.

Finally, I would like to take this opportunity to invite your staff to attend our negotiations on May 23-25 at IHS Headquarters in Rockville, Maryland. This will provide you with a front row view of the IHS circus.

If you have any questions, I may be reached at (612)532-4181. Or you may contact Mr. Dan Milbridge, Commissioner of Health and Human Services, at (612)532-4750. Thank you for your consideration.

Sincerely,

Marge Anderson

MARGE ANDERSON, CHIEF EXECUTIVE
MILLE LACS BAND OF OJIBWE INDIANS

MA/tkb

cc: Vice-Chairman Daniel K. Inouye

BRISTOL BAY AREA HEALTH CORPORATION

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STATEMENT OF
THE BRISTOL BAY AREA HEALTH CORPORATION
FOR THE OVERSIGHT HEARING ON
THE INDIAN HEALTH SERVICE IMPLEMENTATION OF
TITLE III OF
THE INDIAN SELF-DETERMINATION ACT

Submitted to
The Senate Committee on Indian Affairs

May 2, 1995

My name is Robert J. Clark. I am the Chief Executive Officer of the Bristol Bay Area Health Corporation ("BBAHC"). BBAHC is a nonprofit tribal organization as defined in the Indian Self-Determination Act. As such, we have contracted for many years to provide health services to 32 Alaska Native villages in the Bristol Bay and Callista regions, comprising, in general, the Kanakanak Service Unit of the Indian Health Service. We have operated Kanakanak as a tribally-operated service unit in accordance with sanctioning resolutions from the tribal governing bodies of the villages we serve. We have a service population of approximately 7,000. We operate the 16-bed Kanakanak Hospital in Dillingham, a federal hospital formerly operated by the Indian Health Service. It is the only hospital in the 45,000 square mile Bristol Bay region.

In 1994 BBAHC, as a consortium of the Alaska Native villages in our service area, entered into a self-governance compact as a Co-Signer, along with other tribal organizations and Alaska Native tribes, under Title III. The Alaska Tribal Health Compact is by far the largest compact yet negotiated under Title III by the Indian Health Service. We are pleased with some of the new provisions of our agreement with IHS and fully support the concept of Indian tribal self-governance. However, we encountered considerable difficulty in negotiating with IHS and, more importantly, critical provisions of the Alaska Tribal Health Compact and the Annual Funding Agreements thereunder have been violated by the Indian Health Service, resulting in the filing of claims for payment under the Contract Disputes Act by BBAHC and several other tribal organizations with whom IHS had agreed to pay specific amounts by specific dates.

While the IHS Director has informed us in writing on February 24, 1995, that IHS will honor the obligations which it undertook in the Alaska Tribal Health Compact and in the AFAs, we have still not received payment of $541,291 specified for Area Office "tribal shares" in the AFA or for $850,151 specified in the AFA as IHS Headquarters "tribal shares". We are also owed $787,396 for contract support costs associated with the increase in the BBAHC program resulting from the allocation of tribal shares. None of these amounts has been paid although they are expressly undertaken as obligations of the United States in the AFA. We do not think it is appropriate to force tribes to file claims under the Contract Disputes Act or to sue in federal court in order to receive the dollar amounts negotiated by IHS under Title III.

In the exercise of its oversight responsibilities we urge that this Committee monitor compliance by IHS with the commitments which it makes in Title III compacts. These compacts were entered into, in part, to assure that our tribes could access funds at the Area and Headquarters levels and, in addition, to assure that payments could be made in a lump sum amount. The Alaska Tribal Health Compact specifies that these payments will be made within ten calendar days after the Office of Management and Budget apportions the funds. IHS is in flagrant violation of this requirement. We have repeatedly called IHS' attention to this violation and the IHS Director has at least twice (once at a meeting with Alaska Compact representatives and once in writing) confirmed that IHS would comply. Yet it is now more than six months after we began performance of the Compact (October 1, 1994) and IHS has still not met these obligations on which we relied in planning our budget for FY 1995.

We understand that your Committee is considering making the Tribal Self-Governance Project permanent. We support such action but urge the Congress, in doing so, to impose specific limitations on the IHS which will assure full conformity with the goals and philosophy of self-governance and strengthen the ability of tribes to require IHS compliance with the provisions of the Act and with the terms of negotiated compacts and annual funding agreements.

In particular, Congress should make clear that a tribe does not need to sacrifice rights under an existing Title I contract in order to participate in the Title III demonstration. While we have requested the modification of the Alaska Health Compact to include new provisions added to Title I in 1994, IHS lawyers have questioned whether important new tribal rights assured to Title I contractors can be negotiated into our Title III Compact. These include: application of the Prompt Payment Act to late payments by IHS; the cost principles set forth in § 106(k) of the Act; and

the provisions for the use and acquisition of federal property in § 105(f) and § 108(8) of the Act.

We recommend that the new legislation include provisions governing the matters noted below:

1. Appeal Rights. One important difference today between the rights of tribes contracting under Title I of the Act and the rights of tribes negotiating compacts under Title III (or Title IV) is that the federal government in declining a Title I proposal must provide the tribe with an appeal and a "due process" hearing and must carry the burden of proof that it has solid grounds for refusing to contract. In fact its grounds for declining must fall within one of five declination criteria specified in the law. There are specific deadlines within which the federal agency must either negotiate and award the contract or decline it subject to the tribe's right to a hearing. In compact negotiations, on the other hand, the federal representatives may simply walk away from the table if they disagree with the tribe's proposal.

As a demonstration project limited to a specific number of tribes, Title III is dependent on the exercise of IHS discretion to select a tribe to enter into a compact. We urge that the Congress modify Title III to adapt the Title I declination appeal process to the situation under Title III. Once a tribe (or tribal consortium) meets the eligibility requirements for Title III and is formally selected by IHS to participate, then its compact proposal should be subject to the declination criteria and appeal provisions specified in section 102 of the Act. If tribes are encouraged to take advantage of the more flexible funding provisions and other advantages of Title III, it should be made clear that by doing so they do not give up the leverage in negotiating program standards and other terms which the declination procedures afford until Title I. In the 1988 and 1994 Amendments Congress made clear its intention that tribal rights to self-determination contracts are unique and should receive "due process" protection. As self-governance compacts become more and more common (and eventually universal) the important tribal protections afforded by the declination procedures will be lost unless these procedures are also made available under Title III.

2. Eligibility Criteria. We urge that language be included in Title III similar to that in section 402(b)(2) providing that two or more tribes may be treated as a single tribe in order to participate in a compact as a consortium. This provision was included in Title IV to reflect the existing policy of the Department of the Interior. The same policy has been followed by the IHS. The Alaska Tribal Health Compact is an example of its application. In order to avoid confusion, the Act should make

express provision for this approach by IHS, as it already does for Interior.

The eligibility provisions for IHS compacts should also conform to the provisions of section 402(c) of the Act. This would eliminate language in Title III which apparently requires a tribe to participate in two or more Title I contracts to qualify (as well as having three years of clean audits). The requirement for more than one Title I contract to qualify to compact with IHS is especially burdensome since tribes routinely have only one contract with IHS.

3. Reporting. Under Title I a contractor is now only required to file a financial report under the Single Audit Act annually. All other program and financial reporting is subject to negotiation and to the declination appeal procedures in the event that the IHS and the contractor cannot agree. It is not appropriate for IHS to be able to insist upon more detailed and burdensome reporting in the case of a Title III compact than it can make mandatory in the case of a Title I contract. The permanent IHS self-governance legislation should provide that programmatic and financial reporting (in addition to the requirements of the Single Audit Act) are negotiable and, in the event of disagreement, subject to the declination procedures specified in section 102 of the Act.

4. Program Standards. Title III presently contains no guidance as to the negotiation of program standards. While this gives great flexibility to the parties in determining the program provisions of the compact, it leaves IHS with the ability to insist on mandatory program requirements and to refuse to enter into a compact if these are not accepted. Thus far we have found IHS reasonable in negotiating program requirements. However, the Act should protect tribes against the bureaucratic paternalism which caused Congress to enact P.L. 93-638 in the first place. We recommend that a provision modeled on the 1994 Amendments to section 102 be included in Title III which would provide that a tribe proposing to compact should include program and other standards which it elects to follow in its compact proposal, that these should be accepted by the IHS unless it chooses to decline the proposal, and to provide the "due process" hearing based on the five declination criteria stated in section 102.

5. Federal Property. Title III should be amended to state expressly that tribes entering into compacts may access federal property in accordance with the provisions of sections 105 and 108(8) of the Act. We believe that tribal rights under section 105 may be applied to compacts through negotiations under Title III. However, as noted above, IHS legal counsel questions whether

these provisions can be negotiated into Compacts. Curiously, this would mean that no statutory provisions on the use and acquisition of federal property apply to Title III Compacts although IHS has continued to provide the Kanakanak Hospital (which is federally-owned) for our use.

6. Re-design. The permanent legislation should retain the present language of section 303 providing for tribal re-design of programs and reallocation of funds. Such rights should not be restricted, as they are in Title IV, since the provisions in Title IV are adapted to certain types of programs funded through the Department of the Interior.

7. Construction. IHS legal counsel has, without rational foundation, questioned whether the function of construction may be included in a Title III compact. We understand that, more recently, IHS counsel has concluded that construction funds may be included in Title III compacts but that a Title I contract must then be negotiated with a compacting tribe to carry out the construction project. This requirement for two instruments between the IHS and the tribe makes no sense. Congress should include a provision in Title III similar to section 403(e), expressly providing for the negotiation of construction contracts (including FAR clauses) but in the event of an impasse giving the tribe a right to a declination notice and a hearing based on the declination criteria and procedures (provided for in section 102 of Title I.

8. Allowable Costs. Title III should be amended to assure that the provisions relating to allowable costs contained in section 106(k) apply to compacts. As noted above, IHS legal counsel has questioned whether IHS' authority under Title III is broad enough to negotiate the § 106(k) cost principles into an AFA. We disagree but the matter should be clarified by law.

9. Reassumption. At present provisions for the cancellation of compacts are subject to negotiation between the tribe and IHS. There are no mandatory reassumption requirements under Title III. We think this aspect of Title III should remain as it is. In Title IV provision has been made for the Secretary of the Interior to reassume Interior programs under compact without any of the procedural safeguards for an appeal and a hearing which safeguard tribal rights under Title I. If any reassumption provisions are included for Title III compacts, they should include the procedural protections for tribes which are contained in section 109 of the Act.

10. Use of Federal Employees and Supply Services. Under our present AFA IHS retains dollars from our AFA budget which are earmarked for federal IPA/MOA employees detailed to work for us and also retains an amount against which we can charge supplies from the IHS Central Warehouse. We have requested the right to pay IHS for this "in-kind" assistance as it is negotiated and becomes available. By requiring deductions "up-front" IHS reduces our funding level inequitably. We have been informed by IHS that federal law would now permit us to retain funds for IPA/MOA salaries and reimburse IHS for the salaries of such employees (although IHS policy has not allowed this arrangement). IHS negotiators have tentatively agreed to permit a clause allowing such reimbursement in our FY 1996 AFA. However, we are told that federal law does not permit a similar arrangement for supplies, specialty clinics or other goods or services which we may wish to purchase from IHS. We urge that your Committee propose an amendment along the lines of 5. U.S.C. § 3373 (which sanctions reimbursement in the case of details or assignments of federal employees to Indian tribes and tribal organizations). The amendment should apply to supplies, specialty clinics, etc., as well as to IPA/MOA employees.

11. Waivers of Regulations. As amended in 1994, section 107(e) establishes procedures and timelines for action on requests for waivers of regulations submitted by Title I contractors. Title IV now provides that a waiver request will be granted unless the waiver is prohibited by law. At present no such provisions are included in Title III. We think Title III should provide that waivers of regulations will be granted unless the refusal to waive can be justified under the procedures and criteria set forth in section 102.

12. Prompt Payment Act; Late Payments. Under section 108 of Title I IHS is liable for interest on late payments under Title I contracts. A provision should also be added, making Ch. 39, Title I, U.S. Code (the so-called Prompt Payment Act), applicable to Title III. A tribe should not be expected to give up this right merely because it participates in the Title III demonstration. The failure of IHS to comply with the provisions of payment of our FY 1995 Annual Funding Agreement demonstrates the importance of the right to interest on late payments.

We appreciate the opportunity to present the views of the Bristol Bay Area Health Corporation and its member tribes on the Title III Self-Governance Demonstration Project. The firm of Hobbs, Straus, Dean & Walker has represented us in negotiating the Alaska Tribal Health Compact and our Annual Funding agreement, and they will be able to provide the Committee with additional information as to the problems we have experienced in compacting and with recommendations as to necessary remedies. In particular we urge you to consult with our attorney, Bobo Dean, on the current status of our efforts to enforce the FY 1995 Annual Funding Agreement and the need for communication between your Committee and the Indian Health Service to resolve the issues which are unresolved in our FY 1996 AFA negotiations.

Hoopa Valley Tribal Council

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Dale Risling, Sr.
Chairman

HOOPA VALLEY TRIBE
Regular meetings on 1st & 3rd Thursdays of each Month

TESTIMONY OF DALE RISLING, SR., CHAIRMAN
HOOPA VALLEY TRIBE OF CALIFORNIA
BEFORE THE SENATE COMMITTEE ON INDIAN AFFAIRS
OVERSIGHT HEARINGS ON THE IMPLEMENTATION OF THE INDIAN HEALTH SERVICE (IHS) SELF-GOVERNANCE DEMONSTRATION PROJECT
MAY 2, 1995

Mr. Chairman I am Dale Risling, Sr., Chairman of the Hoopa Valley Tribe of California. First, I would like to thank you for your role in making Self-Governance a permanent authorization within the Department of Interior. The Hoopa Tribe is advancing at a steady pace under this new Federal-Tribal relationship.

At this time I would like to share some areas of concern and experiences that the Hoopa Valley Tribe has had under the IHS Self-Governance Demonstration Project.

As you are aware there are currently twenty-nine Tribes with direct IHS Compacts and over 200 Tribes under the Alaskan IHS Consortium Compact. This represents nearly 1/2 of the Tribes in the nation and a transfer of 270 million dollars to Tribal control and administration. That's a substantial change in the last two years. I am happy to report that our Alternative Rural Community Hospital at Hoopa will be opening this next year, in which Self-Governance played a major role. Like self-governance within the Interior Department, the Self-Governance demonstration Project within IHS, with the help of this committee, will become a permanent relationship between HHS and Tribes in the future.

MAINTAINING THE DEMONSTRATION CHARACTERISTIC OF THE IHS SELF-GOVERNANCE DEMONSTRATION PROJECT

Secretary Shalala and Dr. Trujillo have expressed their support for Self-Governance, however, there is substantial opposition down throughout the bureaucracy. This opposition is in the form of rumor and misinformation about Self-Governance to other Tribes and Administration officials. This situation has created a major obstacle to Self-Governance Tribes. We ask for this committee's support by sending a strong message to the Administration through appropriate language, directing the Administration to honor the demonstration characteristic and purpose of SGDP. That they work together with compacting Tribes to help design and demonstrate to Congress, the Administration, and Tribes, a new and better way of doing business between Tribes and the U.S. That is after all, the intent of Congress and participating Tribes. In this relationship Tribes must be assured that they are not held to higher performance standards than the IHS under Self-Governance and a mutually applied Tribal/Federal performance evaluation system must be instituted.

It is important that it be understood and accepted by the administration that each Tribal compact will differ depending on the tribe's capability, resources, and needs. Therefore, Tribal independence, uniqueness and flexibility must be respected and honored instead of attempts that are made to impose inflexible nationalized standards and policies on compacting Tribes.

THE OFFICE OF TRIBAL SELF-GOVERNANCE (OTSG) WITHIN IHS

The Office of Tribal Self-Governance must be elevated to the level of the Secretary of HHS. The OTSG is currently located under the Director of IHS. It is unreasonable to think that fair and impartial negotiation can be accomplished when one party is a negotiator and at the same time is charged with implementing the process and policies between the negotiating parties. It is also important that the office be elevated to the Secretary's office because it is likely the HHS will become the next department to authorize all of its agencies to compact with Tribes.

In regards to staffing of the OTSG we ask for the support of this committee to end the lengthy delay in hiring a director. This delay has greatly impeded important decision making by IHS on essential policies and methodologies, such as Central Office joint allocation methodology, identification of residual resources, and user population definitions. As a result the SGDP negotiations has been stymied in some areas. In terms of other staffing in the OTSG, Tribal consultation must be included in the hiring and organizational planning to assure that only essential personnel are hired and that another bureaucracy is not created.

I am also concerned that the IHS continues to utilize the Council of Area and Associate Directors (CAAD) in the Self-Governance negotiation process, and as offense to Tribes, we are given the opportunity to appeal a decision by the CAAD. Therefore, I recommend that the Committee direct the IHS to review the CAAD charter, in consultation with Tribes, to determine its most appropriate role, if any, in the present-day administration of health services to Indian people. Additionally, I recommend that the proposed IHS Self-Governance Policy Council not be established until the IHS and Tribes can mutually agree on its purpose and role in Self-Governance implementation.

FUNDING CONCERNS RELATED TO IHS SELF-GOVERNANCE DEMONSTRATION PROJECT

Self-Governance was intended to be the process of restructuring for the IHS. As Tribes negotiated their shares of IHS resources the IHS was to reduce and restructure accordingly, including FTE reductions. The Clinton National Performance Review objectives to streamline the bureaucracy and reduce FTE's has interfered with, and complicated this once simple self-governance principle. The intent of restructuring under Self-Governance was to invert or reverse the pyramid of only one dollar out of ten allocated for Indian purposes getting out to Indian people; and to get the nine dollars out to Tribes where it belongs. The Hoopa Tribe requests that this committee insert appropriate language that will assure that any cost savings realized through current and future Federal streamlining, be made permanently available to

Tribes for their respective budgets or to improve field operations that are mutually agreed upon by Tribes. The IHS should be directed to develop a Self-Governance restructuring plan with Tribal consultation, and report to Tribes on its progress on an ongoing basis. I am also concerned that as the Federal government reduces in size and FTE's that the Self-Determination and Self-Governance options for other Tribes will also diminish, this should not be the case.

I question whether or not Administration policy makers, department-wide budget personnel or OMB really understand the treaty commitments, trust responsibility, and the fundamental principles of self determination and self governance. If they do, then I would expect other health care agencies such as the National Institute of Mental Health, The National Institute On Drug Abuse, and health resources which have traditionally been provided to states and cities would also be made available to Tribes, as well as access to social services block grants which we've been denied for the past decade.

The Hoopa Tribe opposes the concept of receiving block grants through state governments; instead we support block grant set asides specifically for Indian Tribes.

CONTRACT SUPPORT COSTS

Finally, The Hoopa Valley Tribe strongly opposes the IHS FY 1995 contract support cost draft policy and requests this committee intervene. If enacted this policy will have a devastating effect on Tribal government operations and decrease a tribe's ability to redesign its health care delivery system based on Tribal priorities.

This draft policy is clearly contrary to the spirit and intent of P.L. 103-413, Tribal Self-Governance Act of 1994, Section 303(a)(g) which mandates that Title III Compacts include 106(a)(2) funds (Contract Support Funds) within the Annual Funding Agreements.

I request that adequate funding for the Indian Self-Determination Fund (ISDF) be appropriated for the assumption of new and/or expanded health care programs. The current ISDF is inadequately funded at $7 million. The FY 1995 estimated shortfall is $39 Million.

In conclusion, I thank you for this opportunity to share with you some of the Hoopa Tribe's concerns and experiences as a first tier IHS and Interior Self-Governance Tribe.

Thank you.

TSC\IAIHS 641

TESTIMONY OF INDIAN HEALTH SERVICE

SENATE COMMITTEE ON INDIAN AFFAIRS OVERSIGHT HEARING

ON

IMPLEMENTATION OF SELF-GOVERNANCE DEMONSTRATION PROJECT

Mr. Chairman and Members of the Committee:
Thank you for the opportunity to discuss the implementation of the Self-Governance Demonstration Project (SGDP) by the Indian Health Service (IHS). I am Michel E. Lincoln, Deputy Director, IHS. I am accompanied by Ms. Luana Reyes, Acting Director of Headquarters Operations, Mr. Reuben Howard, Acting Director, Office of Tribal Self-Governance, and Mr. Douglas Black, Associate Director, Office of Tribal Activities of the IHS.

The spirit and intent of the self-governance law and policy is consistent with the IHS Director's vision that the agency provide for the direct participation of tribes in the development and management of Indian health programs.

The IHS Self-Governance Demonstration Project (SGDP) which provides for the compacting of their health care was authorized in October 1992 pursuant to Public Law 102-573, the Indian Health Amendments of 1992. Last year, P.L. 103-435 extended this authority to 18 years and requires the addition of up to 30 tribes for each fiscal year.

In May 1993, the Agency began its first compact negotiations with tribes under the demonstration authority. Since that time, the Agency has entered into 29 Self-Governance (SG) compacts and 41 annual funding agreements through Fiscal Year (FY) 1995. These compacts transfer approximately $272 million to 197 tribes in Alaska and 28 tribes in the lower 48 states participating in the SGDP. As part of these agreements, we have negotiated the transfer of $248 million in program services and $24 million in IHS administrative funds associated with the transfer of non-residual functions, activities, and services from Area and Headquarters budgets to the tribes to carry out these responsibilities. We are presently beginning the negotiations process for FY 1996.

On April 18, 1995, the Director, IHS, announced three key policy decisions that are critical to the continued implementation of the SGDP in FY 1996. These decisions address important policy questions about residual resources, user population as a factor in resource allocation, and resources allocation methodologies. The Director based his decisions upon the analyses and recommendations made by three Joint Tribal/IHS workgroups, which were established specifically to provide guidance to the Agency in these essential policy areas. These decisions will be refined in FY 1997 and future years.

In summary, the Tribal/IHS Residual Workgroup recommended estimate of $15.56 million as the Headquarters residual, plus the

negotiated Area Office Residuals will be used to calculate tribal shares for the FY 1996 compact negotiations. The $15.56 million represents approximately 1 percent of the IHS services budget in FY 1994 dollars.

The Agency plans to use the existing user population definition for the FY 1996 negotiations. While the Tribal/IHS User Population Workgroup recommendation to change the definition to a facilities-based count has merit, the Agency will have to conduct a full analysis of its impact before it could be adopted.

The Tribal Size Adjustment (TSA) methodology recommended by the Joint Allocation Methodology Workgroup has been adopted as the approach that best maintains fairness as a basis for allocating Headquarters General Pool resources. The TSA methodology bases 87 percent of the allocation on population and 13 percent on the total number of tribes. The allocation methods for the remaining categories of funds will be based on longstanding legislative provisions, program experience, and feasibility.

These decisions are critical to the upcoming FY 1996 compact negotiations. They will, of course, also be applicable to the Title I contract negotiations in accordance with Public Law 103-413. The decisions have been communicated to all tribal leaders and the Committee staff was briefed by the Director, IHS, last week. We are prepared to provide additional briefings to the Chairman, members of the Committee, and staff upon request. At

this time, we would like to make a copy of the complete packet, including the Director's transmittal letter to tribal leaders sent to the tribes, a part of the record.

The Project is administered by the Office of Tribal Self-Governance (OTSG) in the Office of the Director. Efforts to fill the OTSG Director's position are ongoing. The position was readvertised in March and April of this year after a joint IHS/tribal interview team was unable to reach a consensus on the top three candidates. Upon the interview team's recommendation, the position was re-classified and re-advertised at the SES level. The closing date for the announcement was Friday, April 28, 1995, and, as soon as a panel of qualified applicants is certified, the Agency intends to proceed with the interviews.

Since the inception of the self-governance demonstration project, we have always utilized active tribal consultation and participation in the decision making process in the development of policy. This consultation has occurred through a variety of mechanisms including workgroups, workshops and meetings.

The Agency is committed to implementing the SGDP on a collaborative and proactive basis with tribes. In less than 2 years, we are reaching the point where large transfers of program services and administrative funds are occurring through the compacting process. The Title I amendments made by Public Law 103-413 will accelerate this process as tribes exercise their

option to contract for program services and administrative funds on a similar basis to compacting tribes.

We are at a critical juncture in the demonstration project. We must assess the impact of large transfers of funds upon the Agency's ability to carry out its residual functions and to continue providing direct health services to tribes who choose not to contract or compact. The Agency is taking steps to downsize and reorganize in order to free up resources for transfer to tribes but these efforts could be outpaced by the rate of compacting and contracting, given the significant amount of tribal interest.

At this time, the Agency must carefully consider the impact of adding 30 new tribes under the demonstration authority in the coming fiscal year. To assure tribes that the Agency has the ability to make tribal shares readily available to both compacting and contracting tribes, and without causing adverse impact on other tribes, it may be prudent to delay entering new compacts.

The Agency and tribes must also evaluate how the Indian health systems supported by the resources that are being compacted or contracted will be affected. Unintended consequences like the fragmentation of the Indian health program services or reduced access to certain services resulting from the division of limited resources needs to be avoided. We have begun these evaluation

efforts by establishing a joint tribal and IHS workgroup that will develop evaluation design requirements for a major independent evaluation study in FY 1997.

The challenge before the Tribes, Indian health programs, the IHS and the Congress is to retain the Indian health programs' applied expertise in core public health functions that are critical to elevating the health status of American Indians/Alaska Natives (AI/ANs) and reducing the disparity in the health status of AI/ANs compared with the general population. We, who are involved in Indian health care, must deal with a changing external environment with new demands, new needs, and new priorities.

The pursuit of increased efficiency, effectiveness, accountability and integrity must be intensified while maintaining our customer focus. As stated in the Director's vision statement for IHS, "Change must be accomplished so that our customer, the American Indian and Alaska Native patient, only notices improved quality of care. The needs of our patients and our communities are always paramount because they honor us when they come to us for care." We must continue to work together in partnership to achieve this goal.

This concludes my prepared statement. We will be pleased to answer any questions that you may have.

QUESTION #1(a)

In presenting the testimony of the Indian Health Service, Mr. Michel Lincoln indicated that the IHS does not intend to negotiate any additional Self-Governance Compacts in fiscal year 1996 despite the change in law authorizing up to 30 additional compacts each year, beginning with 1996. The Committee is advised that letters of intent to enter into Compact negotiations were sent to certain tribal governments and that planning grants were made available to prepare those Tribes for the compact negotiation process.

Given the expectations that such actions on the part of the Indian Health Service have engendered, and the reliance the affected Tribes have placed on IHS actions, what is the basis for imposing a moratorium on any new compacts in fiscal year 1996?

ANSWER:

The IHS has demonstrated its commitment in implementing the Self-Governance Demonstration Project (SGDP) by negotiating compacts that represent 225 tribes, which is significantly higher than the 30 tribes that was originally authorized as late as October 1994. This effort has resulted in the transfer of $24 million in Tribal Share (TS) funds associated with Area office and Headquarters administrative\management functions, activities, and services which the SG tribe is now responsible to provide. In order to provide the resources associated with the transfer of these responsibilities to tribes wanting to participate in the SGDP, the IHS will continue to restructure and downsize. However, it will take some time to accomplish this additional restructuring and downsizing at the Area office and Headquarters levels. In addition, during FY 1996, IHS will assess Self-Governance compacting so that this demonstration project continues to be successful and the rights of those tribes not compacting are protected. The IHS is committed to the success of tribes who choose contract compact or directly receive their care from the IHS. The IHS will decide whether or not to increase the number of compacts in FY 1996 based on the findings of the assessment of all self-determination activities.

QUESTION #1(b)

If more compacts were added in 1997, will a priority be extended to those Tribes that have expended considerable time, energy and resources in preparing themselves to enter into compact negotiations in fiscal year 1996 based upon their reliance on representations made by the Indian Health Service?

ANSWER:

Yes, the IHS will give priority to those that have received IHS planning grant funds and completed plans.

QUESTION #2(a)

We have just begun the eighth month of the fiscal year and Tribes inform the Committee that IHS has yet to distribute any of the negotiated tribal shares of Headquarters and Area Offices.

Why have you delayed the transfer of these funds?

ANSWER:

The delay in transferring the Fiscal Year 1995 tribal shares is attributed to the necessity to reconcile negotiated amounts with actual congressional appropriations. The process is complex and time consuming.

QUESTION #2(b)

When will these dollars be made available to tribal governments?

ANSWER:

The IHS has initiated the payment process for the transfer of Tribal Shares to the Tribes and IHS expects payments to be completed by the first week in August.

QUESTION #2(c)

What steps have been taken to ensure that delays in the transfer of funds associated with the allocation of negotiated shares are not repeated in future years?

ANSWER:

Before the end of this fiscal year, the IHS will finalize a process that will provide for a more timely payment of the Fiscal Year 1996 tribal shares in a more responsive and expeditious manner.

QUESTION #3(a)

The Committee has heard from Tribes who strongly oppose the recent IHS decision to refuse payment of contract support funds to cover tribal indirect costs associated with administering tribal shares of Area and Headquarters accounts.

Once a Tribe has negotiated an indirect cost rate with the Office of Inspector General, what legal authority does IHS have to fund some shares and not others?

ANSWER:

Indirect contract support costs (CSC), once negotiated between the tribe and the cognizant IG (over 80% of Federally recognized tribes have DOI IG as their cognizant Agency), are funded according to IHS policy, as developed with the participation of all tribes.

Current IHS policy provides funding for CSC from funds specifically appropriated (as requested in the Presidents budget or added by the Congressional budget appropriation actions). By definition in Section 106(a)(2) of P.L. 93-638, as amended, CSC are authorized to be paid in addition to funds which the agency was spending on any tribe. CSC are also based on each tribe's need, as negotiated with the IG.

For new and expanded programs, CSC is provided from additional annual CSC funds on a first come first serve basis. For ongoing contracted programs, mandatory increases in the CSC budget line item are distributed proportionately according to each contractor's increased need over the previous year (relative to all other contracted or compacted programs).

IHS CSC policies for 1) consistent identification of need; and 2) allocation of resources to meet the identified need is reviewed periodically with tribal representatives, to ensure that policies are well understood and well supported by tribal consensus. In a meeting scheduled for July 6-7, 1995, tribes will work with the IHS to revise current policy in accordance with the applicable provisions of the Self-Determination Amendments of 1994.

QUESTION #3(b)

Has IHS considered downsizing its administrative staff in order to fully fund its contract support obligations to Tribes operating programs under Titles I and III?

ANSWER:

The IHS is in the process of downsizing its administrative staff consistent with Title III, National Performance Review, administrative cost, budget, and FTE reductions. The Indian Health Design Team (IHDT) is also developing options for restructuring activities. These savings have not been directed to pay CSC. Currently, the Congress appropriates a specific amount of funds in a separate budget activity for CSC and IHS has not proposed to reprogram funds appropriated for other purposes to increase funds available in CSC. In order to provide equitable opportunities for Title I contractors and Title III compactors, and to comply with appropriation Committee directives to control the escalating amount of contract supports costs required, tribes will participate in determining a revised policy as well as alternative methods of meeting the CSC funding requirement at a meeting to be held in Denver on July 6-7, 1995.

QUESTION #4(a)

In our February budget hearing, you testified that IHS was going to "redeploy" 176 FTE positions from existing operations to staff new health facilities.

How do you respond to tribal assertions such a redeployment will reduce IHS-supported staff at the service units of other Tribes.

ANSWER:

The IHS will redeploy FTE from multiple sources to support the 176 FTE to staff these new facilities. It is estimated that approximately 134 FTE positions will be saved in FY 1995 from tribal compacts and contracts at service units. There also will be 208 administrative and management staff leaving the IHS due to buyouts in FY 1995 and FY 1996. And there will be approximately 250 to 350 staff currently on temporary and term appointments that will be filled through the use of personal services contracts.

QUESTION #4(b)

Will shift staffing funds out of the reach of the Self-Governance negotiations of those other tribes?

ANSWER:

There will be no transfer of funds because Congress has appropriated specific funds to staff new facilities.

QUESTION #5

The Committee has received complaints from Tribes that their negotiations with IHS have been frustrated and lengthened by the fact that key IHS decision-makers are not at the table. What will you do in the pending negotiations for fiscal year 1996 to ensure that the IHS negotiators at the negotiation table have full authority to evaluate the tribal negotiation positions first-hand and respond with appropriate adjustments to the IHS negotiation positions?

ANSWER:

The individuals that have been selected as the Agency lead negotiators for the Fiscal Year 1996 Self-Governance negotiations have been provided with the appropriate authority to make decisions in accordance with established IHS policy. In addition, a tribal appeal process is in place.

QUESTION #6

For nearly two years, Tribes trying to access the IHS "active users " data base used to develop tribal shares have said the IHS system loses data Tribes put in, or it scrambles the data in a manner that makes the data highly unreliable. What is IHS going to do to make this system useful to Tribes and when do you intend to do this?

ANSWER:

The IHS has reviewed the Patient Registration System to identify potential points where registration data may not actually be reaching the data base. In order to make this system more useful to tribes, the IHS has established a joint Tribal and IHS user population workgroup. One of the workgroup responsibilities is to review and provide recommendations on how the validity and the accuracy of the user population data can be improved. The workgroup was unable to complete this task in time for the Fiscal Year 1996 negotiations. However, the workgroup has made preliminary recommendations to IHS and the tribes. The workgroup will continue to address this issue and complete its task within the next six months.

QUESTION #7(a)

The Committee is advised that the Department has kept away from the negotiation table a 35-million dollar "administrative assessments" account, although the law clearly requires the IHS to make available for tribal share negotiations all funds related to the provision of services to a Tribe, including Federal administrative costs. The Congress expects IHS administrative costs for payroll, rent, supplies, and telephones to be reduced as Tribes assume more of these responsibilities, and expects funds which were previously expended at the federal level to be transferred to the Tribes.

Will the Department negotiate tribal shares of this 35-million dollar account as required by federal law for fiscal year 1996?

ANSWER:

As addressed in the Tribal Leader Letter of April 18, 1995, the IHS would be placed at financial risk of being anti-deficient if it could not pay its bills for these administrative costs. These costs could not be reduced in time for the FY 1996 negotiations and therefore, the funds will be unavailable for the 1996 negotiations. It should be noted that most of the costs associated with these administrative assessments are already provided to tribes through contract support cost funds as indirect costs.

QUESTION #7(b)

If not, under what legal authority does IHS withhold these funds?

ANSWER:

To pay tribal shares for these charges imposed by outside agencies would cause IHS to either be anti-deficient or to reduce services to other tribes which is prohibited under Title III, Section 306 of P. L. 93-638.

QUESTION #7(c)

What steps have you already taken with the Public Health Service and the Department to initiate the workgroup you mentioned will be studying this administrative assessments account?

ANSWER:

The Agency has transmitted this request to PHS and is awaiting a response. The workgroup will study user fees, cost analysis and equity formulae.

QUESTION #7(d)

When will its review and recommendations be completed?

ANSWER:

The Agency will request that this review be completed by the end of Fiscal Year 1995.

QUESTION #7(e)

Will its recommendations be applied to fiscal year 1996 negotiated agreements?

ANSWER:

The 1996 negotiated agreements will be signed prior to the recommendations from this review. However, if some of the recommendations result in immediate cost savings to the Agency in fiscal year 1996, we will negotiate amendments to the 1996 negotiated agreements to reflect these savings.

QUESTION #8(a)

We all recognize that the need for Indian sanitation and health facility construction is fast outpacing the availability of appropriated funds.

Has IHS developed any other financing options which could leverage private financing or provide for lease purchase arrangements and thereby begin construction that could be paid for over time? If so, please provide the Committee with a detailed description of the various alternative methods.

ANSWER:

There may be approaches that could help tribes leverage private capital and construct replacement health facilities. However, a full analytical assessment of the cost and policy implications of any alternative under development must be conducted to evaluate feasibility. It would be pre-mature to discuss any alternative without a better sense of budgetary and programmatic effects.

We do know that facility construction costs are only a small part of the life cycle costs of a facility. Construction of new health care facilities results in direct effects on the health services portion of the IHS appropriation. Expanded facilities generally require additional staffing and operational funding. Efforts to facilitate the ability of tribes that are most financially able to upgrade their facilities can therefore result in disproportionate allocations of staff and operating funds to those tribes; e.g., it will drive an inequitable distribution of funds and health care service resources to those tribes that are most affluent. In addition, cost to maintain and improve new facilities would not be insignificant, especially since current Maintenance & Improvement (M&I) funding allows IHS to conduct only the most essential maintenance projects.

There are alternatives available that tribes may consider to leverage funds and construct sanitation facilities. Some of the issues to consider follow:

-- Private capital investment has been used on trust land in the past to build and operate commercial and industrial facilities. Businesses have built infrastructures, including water and sewer, to serve their operations. Their incentive is always the potential for profit. Tribes also have the ability to pursue private capital to construct residential sanitation facilities. However, the sources of private capital view this as a high risk venture with little profit potential. Commercial bank loans and bonds cannot be secured without collateral or a guaranteed local revenue stream.

-- Currently, Indian tribes can participate in EPA's revolving loan program for wastewater facilities construction. This program will be expanded to include drinking water facilities if the Safe Drinking Water Act is re-authorized this year. Each State administers the program for EPA

QUESTION #8(b)

What steps has IHS taken to involve Tribes in the development of alternative financing methods?

ANSWER:

IHS has met with a number of Tribes interested in using existing authorizations for alternative funding methods for which funds have not been appropriated. Also, some Tribes have expressed an interest, on their own, in other alternative methods of financing construction of health facilities. IHS continues to provide technical assistance to tribes including those seeking alternative methods of financing of sanitation facilities construction.

QUESTION #9

Reinvention and other down-sizing efforts are affecting IHS. The Congress has always expected IHS to reduce its operations to reflect the transfer of functions, services, activities and services to Tribes under Self Governance. Please provide the Committee with specific examples of how the IHS has been correspondingly reduced in size and shape after a Tribe has taken over responsibilities the IHS had previously undertaken for the Tribe?

ANSWER:

The IHS Headquarters has transferred specific functions, services , activities and the resources to support those transfers to the Self Governance tribes. This early in the demonstration project, the agency has not been able to discern a decrease in requests for services by Self-Governance tribes. In fact, the negotiations process represent an increased workload.

The IHS Headquarters and Area Offices have downsized as a result of attrition and buyouts. The Headquarters and Area Offices have reduced staffing by 16% and 22%, respectively since 1993.

QUESTION #10

We are informed that the Nashville Area Office has led Tribes to believe that it will refuse to negotiate and fully fund tribal shares in fiscal year 1996. What specific action are you taking to require Area Offices to both negotiate and fully fund tribal shares for fiscal year 1996?

ANSWER:

In response to the concerns raised by the Nashville Area tribes, the IHS Office of the Director has convened a management team to address the tribes' concerns. This team is working to assure this matter is resolved to the satisfaction of the tribes and the IHS. In addition, the IHS has directed all Area Offices involved in SG negotiations to negotiate in good faith and to continue to work with all tribes in their area to restructure and downsize to a level that will reduce the amount of shortfall needed to offset the funding of Tribal Shares.

QUESTION #11

The Committee is advised that the Office of General Counsel has issued another opinion that continues to interpret the statute to intend the anomalous result that a Tribe may contract under Title I for the management of construction activities but may not Compact under Title III to manage such construction activities. Please provide the Committee, either from your office or the Office of General Counsel with specific statutory language which would authorize a Tribe to manage such construction activities and to administer all other IHS programs and functions under a Title III Compact.

ANSWER:

The opinions of the Office of the General Counsel on the issue of construction addressed the actual construction of a Federal project. We are not aware of any opinion which addresses the question of whether the law would authorize a tribe to compact under Title III to manage construction activities.

QUESTION #12

During the past 24 months, on what dates did IHS request and receive reduction-in-force authority and how many FTE's per year does IHS plan to reduce in fiscal years 1995, 1996 and 1997 to free up funds to help pay Title III and Title I tribal shares?

ANSWER:

The agency has not found it necessary to conduct RIF/RIS in Area Office's or Headquarters to provide tribal shares. The agency has been able to downsize through buyouts and attrition. The Headquarters and Area Offices have reduces staffing by 16% and 22%, respectively since 1993. Efforts will continue consistent with recommendations from the Indian Health Design Team and all other available management tools.

QUESTION #13

Does IHS plan to fully fund all Area and Headquarters tribal shares in fiscal year 1996? If not, what level of tribal share funding is IHS planning to make available and what is the legal authority for this proposed position?

ANSWER:

The IHS plans to fund 100% of negotiated FY96 Headquarters tribal shares. The full demand for Area tribal shares needs to be assessed. The intent of the IHS is to fully fund Area negotiated tribal shares. The IHS must ensure that obligations to tribes receiving services directly from IHS and Title I contractors are met and support provided by IHS to other tribes is not jeopardized before a commitment can be made for 100% funding at the Area level. Section 306 of the Act is the legal authority for this position.

For Title III compacts, the IHS has been able to fund 100% of Tribal shares by relying on a self-governance shortfall authority. Unfortunately, no similar shortfall authority exists for Title I contracts.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20857

APR 18 1995

Dear Tribal Leader:

During the past year, Tribal/Indian Health Service (IHS) workgroups examined policy issues that initially were identified as being important to the continued implementation of the Self-Governance Demonstration Project. In the meantime, the Indian Self-Determination (ISD) Amendments of 1994 required the IHS to examine the applicability of these policy issues to self-determination contracts as well. The policy issues addressed were in the areas of residual resources, user population as a factor for resource allocation, resource allocation methodologies, and contract support costs. Reports from the Residual, User Population, and Joint Allocation Methodology workgroups were delivered to the Director, IHS, and included options and/or recommendations for action.

I am writing to inform you of my decisions on recommendations made by three of the workgroups. These decisions apply to both Title I contract and Title III compact negotiations. My decision regarding a policy on contract support costs will be covered in a separate letter. This letter summarizes each decision and references the next steps in the continued implementation of the self-governance and self-determination authorities. The enclosed policy decision papers provide additional information on the recommendations and decisions, their implementation, and needed followup actions.

RESIDUAL

As the basis for fiscal year (FY) 1996 negotiations, I have accepted the Tribal/IHS Residual Workgroup recommended estimate of $15.56 million as the Headquarters residual. I also accept the workgroup's recommendation that an amount for Area Office residuals be developed with local tribal participation, based on the assumptions developed by the workgroup.

The three options for calculating the resources that the IHS would require to carry out residual activities, functions, and services as defined in the report, assumed that (1) 100 per cent of tribes would negotiate and sign self-governance compacts and annual funding agreements, and (2) all Federal construction is compactible. Because of the difficulty of making accurate estimates under those assumptions, the options were submitted as goals. While I consider the goal to be reasonable in theory, other factors need to be considered in practice. For example, the estimate is based on an average full-time equivalent (FTE) cost in FY 1994 dollars, and does not account for inflation or

administrative support for the FTEs. Nevertheless, for FY 1996 negotiations, the $15.56 million represents an established goal for the residual for IHS Headquarters.

It will take time to reach that goal from where we are today. To move in a deliberate way toward the goal, additional analysis and evaluation will be undertaken by the IHS and tribes on an annual basis. Please refer to Tab 1 for a complete description.

USER POPULATION

For FY 1996 negotiations, I have decided that the IHS should continue to use the current residence-based active user population definition and estimates.

While the Tribal/IHS User Population Workgroup's recommendation is an excellent idea and has merit, a thorough analysis of its impact must be done prior to implementation. The new definition proposed by the workgroup would have changed to a facilities-based count. As a result, individuals seeking services in more than one facility would have been counted more than once, i.e., the total active user population would represent a duplicated count. The resulting counts would represent significant changes in the data for some IHS Areas. These changes, in turn, would directly affect the level of resources allocated to all tribes. Because any decision on this issue will have long-term effects, I decided that it would be prudent to fully analyze the implications of any change. As a part of this analysis, the IHS and tribes must address an additional unresolved issue of establishing the user population for new tribes as they are recognized.

The workgroup recognized that more analysis was needed, indicating in their report that time limitations prevented them from examining all potential options for allocating resources. The workgroup recommended further identification and evaluation of factors other than user population for resource allocation. Please refer to Tab 2 for a complete description.

JOINT ALLOCATION METHODOLOGY

I have accepted the recommendation of the Joint Allocation Methodology Workgroup that the Tribal Size Adjustment (TSA) methodology be used for the Headquarters General Pool. I believe this methodology best meets the public health and preventive services program goals for American Indian and Alaska Native health and attempts to maintain fairness as a basis for allocating resources.

The TSA method represents a process that continues to consider the total active user population as a significant allocation factor for all tribes. I believe that the method strikes a reasonable balance that is consistent with long-standing IHS principles of resource allocation.

The decisions on recommendations for the remaining 17 categories include those on which I concurred, concurred with modifications, or did not concur based on congressional intent, experience, and feasibility. Some will use existing methodologies until additional study and analyses are completed, and some methodologies will continue unchanged. Please refer to Tab 3 for a complete description.

SUMMARY

I have carefully reviewed the workgroup reports and the available comments received thus far. I have also convened meetings of IHS senior staff to review and revise staff summaries drawn from the reports and comments. The enclosed policy papers are the result of the above review and provide a more detailed discussion leading to the decisions for each of the policy areas.

I am satisfied that these complex policy issues have been addressed in a deliberative and inclusive manner. Each workgroup report acknowledges that more work needs to be done to achieve fairness in setting policy for the IHS. I am committed to followup actions to enable this work to be done expeditiously.

I believe that these decisions reflect a philosophy of full support and endorsement for greater self-determination and self-governance for all tribes. I have listened to and tried to balance the concerns and thoughts of all tribes, tribal organizations, IHS employees, the Administration, and the Congress. I believe these decisions are good for the future of American Indian and Alaska Native health, enabling tribes to make decisions about services to their communities, while continuing a Federally operated health program for those tribes that choose that system.

I appreciate the hard work and commitment shown by all who have contributed to the examination and development of these policies. I have asked the Area Directors to provide you with any additional information you may need for the upcoming FY 1996 negotiations. Because so many of you have helped in this process, let me close with a message from my Confirmation Hearing remarks: "With the cultural and spiritual strength embedded in

the diversity of the tribal nations, let us come together and realize that we are all one in this universe and in the circle of life." I am committed to working with you and the IHS staff for a better Indian health program.

Sincerely yours,

Michael H. Trujillo, M.D., M.P.H.
Assistant Surgeon General
Director

Enclosures

IHS/TRIBAL RESIDUAL WORKGROUP

Introduction

Residual, the funding amount that the Indian Health Service would require to fulfill its moral and legal responsibilities, has been an issue of discussion since the Self Governance Demonstration Project (SGDP) began. A diversity of opinion arose among tribes and the IHS over the residual functions and funds that would be necessary under 100 per cent compacting. It was apparent that we needed to reach some consensus on this important issue, because identification of residual was necessary to determine what resources from Headquarters could be made available as tribal shares. Accordingly, the Residual Workgroup was established by the Acting Director, Headquarters Operations in September 1994. The Workgroup was charged to:

1. Develop the principles which will govern the identification of resources the Agency will retain to meet its inherently Federal functions should 100% of tribes exercise their right to compact under Self Governance.

2. Develop the principles which will govern the identification of resources the Agency will retain, on a transitional basis, up to the point when 100% of the tribes have entered into compacts under Title III.

3. Develop the specific methods for use in identifying the resources that will be retained upon application of the above principles.

4. Calculate the total amount of resources that will be retained by the Agency applying the principles and methods in 1-3 above.

Workgroup Options/Recommendations

In order to carry-out its task, the Workgroup developed three definitions which would guide its work.

1. Residual: Those activities, functions, and services necessary for the United States government to fulfill and maintain its moral and legal responsibilities based upon treaties, statutes, and Executive Orders that must be carried out by Federal officials.

2. Tribal Shares: Tribal shares of Headquarters and Area resources not determined to be residual and allocated to individual tribes utilizing an agreed upon methodology. This does not include Service Unit or program base.

3. Retained tribal shares: Those resources which support the activities, functions, and services which are not residual, but which tribes elect to leave with the Federal Government to administer.

In response to its primary task, the Workgroup provided three options on residual for the Director, IHS, to consider. However, no options or recommendations were provided related to resources the Agency will retain, on a transitional basis, until 100% of tribes have compacted. Even though the Workgroup did not address transitional funding, the concept of transitional funding is discussed in the "Explanation of Decision" below. The three options the Workgroup provided are:

1. The IHS residual estimate of 720 FTE and $45 million for an Agency-wide residual including Headquarters and Area tasks be used as FY 96 negotiations.

2. A Workgroup derived estimate of 240 FTE and $15.56 million for Headquarters plus an amount for Area FTE and funding based on the assumptions developed by the Workgroup with local tribal participation in the estimate development, by March 31 be used for FY 96 negotiations.

3. A Workgroup derived estimate of 240 FTE and $15.56 million for the Agency-wide residual to be used for the FY 96 negotiations.

Director's Decision

1. I concur with the definitions developed for residual, tribal shares, and retained tribal shares.

2. I accept, in principle, the $15.56 million identified in option number 2 as a goal for Headquarters residual. In the context of an environment where 100% of tribes have compacted for their share of programs, this is goal theoretically possible. I do not concur with the estimate of 240 FTE's (see explanation below).

Explanation of Decision

The acceptance of the definitions requires no additional explanation. However, as implementation progresses, tribes and the IHS may want, periodically, to revisit and review these definitions.

The residual of $15.56 million is a goal that is based on the assumption that 100% of tribes will exercise their right to compact. In establishing a residual resource goal, a dollar target is more relevant than FTE. The Agency would utilize the funds to carry out its residual functions. Its staffing needs

would be determined based on these residual functions. For this reason, I do not concur with the number of FTEs proposed by the workgroup in option number 2.

I accepted this goal because many of the assumptions in the report are consistent with other efforts that will result in a reduced Federal presence. I also believe that it provides a starting point for the Agency to evaluate the entire process using the Workgroup's assumptions and our 18 months experience with the SGDP. It is essential that work continue to better define what the Agency must continue to do on behalf of tribes, and what the tribes can assume themselves, either individually or collectively. I expect this number to change, and by that I mean it could move in either direction. The residual amount also will change as a result of mandatory increases included in the appropriation.

By accepting this option as a goal, I recognize that the issues of transition and retained tribal shares, has not been addressed. I also am aware that the Agency has spent considerable time analyzing its functions, considering ways to do things better, and looking at different structures to respond not only to the SGDP, but also to Self Determination contracting (Title I amendments) and to the Reinventing Government initiative. In this process, the Agency is identifying resources to meet the increased demands on staff related to the self governance process; resources to carry-out functions which benefit all tribes; staff in support of Federal construction; and support for information management systems.

Implementation and Impact

Even though the residual amount of $15.56 million is a goal, this is the amount that will be used in calculating the tribal shares of Headquarters for the negotiations with tribes for Title I and III agreements. At this time, I do not believe that this should present significant funding problems for the Agency during the FY 1996 compact negotiations, based on the President's FY 1996 budget request, because we are dealing with 30 tribes (counting Alaska as 1) and 42 annual funding agreements. As more tribes elect to exercise their right to compact, and as tribes enter into contracts under the new Title I amendments, it may be necessary to look at the transitional amounts required by the Agency to provide services to compacting, contracting, and direct services tribes.

Follow Up Actions

Although a goal has been established for residual, additional work on residual and transition is necessary. The existing

Workgroup will be asked to continue its efforts. In addition, a suggestion will be taken to the Indian Health Design Team that they include this in its deliberations. Some of the issues that will require attention include:

1. Residual

   - Annual analysis of functions and resources required for those functions.
   - Annual evaluation of impact using the goal established for residual.
   - Guidance to Areas in establishing an Area residual that provides for some consistency among Areas.

2. Transition

   - Develop a definition for transition and estimate a time-frame for the transition; this should include the establishment of targets to achieve as the Agency moves towards the theoretical residual.

References

1. IHS/Tribal Residual Workgroup Final Report, February 1995.

IHS/Tribal User Population Workgroup

Introduction

Since the start of the Self-Governance Demonstration Project (SGDP), the Indian Health Service (IHS) has utilized the IHS official user population estimates to determine the Tribal Shares (TS) of IHS Headquarters and Area Office administrative resources. Tribes have questioned the accuracy and completeness of the IHS data upon which the estimates are based, and whether the current user population is the appropriate indicator to use.

As a result, the Director, IHS, established the User Population Workgroup consisting of compacting and non-compacting tribal representatives and IHS staff to address: 1) the validity of the IHS user population estimates, 2) the definition of user population for resource allocation, and 3) alternative indicators for resource allocation. Although the Workgroup did not have time to complete their tasks prior to the FY 1996 negotiations, they submitted to the Director an interim report with a recommendation for the FY 1996 SGDP negotiations.

Workgroup Recommendation

The current definition of user population should not be used to determine counts for allocation of TS for the FY 1996 negotiations. The following definition should be used:

> Every American Indian/Alaska Native, regardless of residence, who is eligible, as defined by 42 CFR 36.12 and P.L. 100-713, and accesses a service within a thirty-six month period.

Director's Decision

I do not concur with the recommendation at this time. The IHS will continue to use the original user population definition for the FY 1996 negotiations, which is:

> The count of American Indians and Alaska Natives by residence that are eligible for IHS services, who have registered and used those services (direct and contract, inpatient and ambulatory medical, and direct dental) during the last three year period as recorded in the IHS Central Data Base.

Explanation of Decision

The Workgroup's recommendation is an excellent idea and has merit, when considering resource requirements for the facilities

providing services. A thorough analysis of the proposed population indicator for the allocation of TS needs to be performed and the technical details for proper implementation need to be worked out. The proposed definition would change the residence-based user population to facility-based. This would result in duplicated counts in those locations where individuals are registered and receive services at more than one facility. Due to the complexity of the issue and the long-term effect of the decision, it is best that the current user population definition be used until the IHS and tribes are confident that the replacement indicator(s) have the desired effect and can be correctly calculated.

Implementation and Impact

The IHS has issued official user population estimates for FY 1994 by Area. The Area-level user population estimates are fixed, are not subject to change, and, therefore, are used to determine the dollar limit for TS by Area. Each Area is to take their Area user population total and divide it among the Tribes in their Area. However, an Area has the option, with tribal involvement and concurrence, of using a variant of the current user population definition for allocating TS within their Area. These Area-adjusted figures will not be used to alter the IHS official user population estimates, and therefore will only affect the distribution of TS within the Area. The Areas should notify the Director, IHS, of any deviations from the standard allocation technique and provide documentation of their methodology.

Other Implementation Issues

New tribes have been federally recognized since FY 1994 and are not reflected in the FY 1994 user population estimates. Decisions are required for the FY 1996 negotiations concerning: 1) whether these new tribes should be considered in determining TS and 2) if so, what methodology should be used in accounting for the new tribes.

Follow Up Actions

I will ask the Workgroup to provide advice on a new tribes policy in order to make an informed decision for the FY 1996 negotiations. I plan to continue the User Population Workgroup so that its findings will be available prior to the FY 1997 negotiations. The Workgroup will be asked to complete its original charge and to consider workload, eligibility, and related issues. The Workgroup is responsible for ensuring that the indicator(s) that are finally proposed are thoroughly evaluated to determine their adequacy and validity for the defined purposes and that they can be properly calculated.

References

1. IHS/Tribal User Population Work Group Draft Report, March 7, 1995.

2. IHS memorandum, "Final User Population Estimates - FY 1994," March 23, 1995.

JOINT ALLOCATION METHODOLOGY WORKGROUP

The Joint Allocation Methodology Workgroup (JAMW), whose membership includes representatives of Compacting and Non-compacting tribes and of the Indian Health Service (IHS), was charged with developing recommendations for distribution of IHS Headquarters funding for fiscal year (FY) 1996 self governance negotiations. The January 26, 1995, final JAMW report with recommendations was submitted simultaneously to the Indian Health Service (IHS) and to tribal leaders for consideration. During several national meetings the JAMW recommendations were discussed, and, subsequently, many comments and letters were received. All have been reviewed and considered, and have contributed to the decisions.

This document is arranged according to the outline of the JAMW Report's recommendations. The Director's Decisions follow each recommendation.

1. GENERAL HEADQUARTERS POOL

Workgroup Recommendation

The General Headquarters Pool is to be distributed using the Tribal Size Adjustment (TSA) methodology.

Director's Decision

I concur with the recommendation. The General Headquarters Pool will be distributed based upon the TSA methodology. Please note that the size of this pool is adjusted annually following an examination of program requirements and available resources. For example, Headquarters reserves are set aside each year to distribute to the Area Offices and/or Service Units based upon special needs. At the end of each year, a portion of those funds are made recurring to the Area base and, therefore, will be distributed in future years from Area tribal shares.

Explanation of Decision

Based on information available, the TSA best approximates the historical Headquarters administrative workload distribution. It recognizes both the threshold of administrative overhead needed for the administration of small health programs or systems, and the economies of scale achieved in the administration of larger health systems. There is an expressed diversity of opinion among tribes about the TSA method.

The subject of allocating health resources is not new to the IHS. For more than a decade the IHS has been working with tribes to develop resource allocation methods that would move toward equity of health services and health resources. In doing so, the IHS and tribes have recognized that allocating resources only on a per capita basis would result in inequitable access to care among tribes nationwide. Past IHS and tribal efforts to attain equitable distribution of resources have emphasized the development of funding strategies most closely associated with the IHS' public health mission and its goal to raise the health status of American Indians and Alaska Natives to the highest level possible. The IHS funding policies have, therefore, been "directed to those means that best promote the elevation of health status for all Indian people collectively; i.e., at those communities with excessive deaths and morbidity and those with no access to any system of health care, rather than simply calculating the per capita dollar expenditures". (See Rhoades letter to Governor Bellmon, May 12, 1990).

A concern expressed by the larger tribes is that the TSA methodology inappropriately provides funding to support administrative infrastructure for small tribes and, therefore, reduces health services to the user population. The funds in the General Headquarters Pool are primarily centrally managed program support funds, rather than direct services funds. Of an estimated FY 1994 amount of $64.67 million, $56.35 million, or 87.1%, is estimated for distribution based on user population. The balance of only $8.32 million, or 12.9%, is estimated for distribution based on the number of tribes. The dollar estimates used by the JAMW for their report were drawn from spreadsheets developed for the fiscal year (FY) 1995 self-governance compact negotiations. The basis for these spreadsheets was actual appropriations for FY 1994 and was adjusted to $59.7 million, when the actual FY 1995 appropriations level became available.

References

1. E. R. Rhoades, M.D.,former Director, IHS, letter to Governor Henry Bellmon, State of Oklahoma, May 12, 1990.

2. Indian Health Care Improvement Act Amendments of 1984

3. Health Services Priority System - 1986

2. EMERGENCY FUNDS

Workgroup Recommendation

The Emergency Funds are to be narrowly defined and restricted to public health emergencies. Prior to the end of the fiscal year, a summary report on the use of these funds is to be issued to the tribes. Tribal shares should then be identified for any remaining balance and distributed accordingly.

Director's Decision

I concur with the recommendation with the following modification to the definition. Expand the definition to not only handle public health emergencies, but also to resolve possible financial difficulties, i.e., Anti-Deficiency Act, and other unforeseen problems that are appropriately resolved using executive discretion. Throughout the year, any tribe may be the recipient of these non-recurring emergency funds. Any funds remaining at the end of the year will be available for distribution in accordance with the TSA methodology.

3. CATASTROPHIC HEALTH EXPENDITURE FUNDS (CHEF)

Workgroup Recommendation

The CHEF funds continue to be distributed retroactively (reimbursed) for catastrophic costs based on the current IHS method.

Director's Decision

I concur with the recommendation. This is consistent with my position last year, as stated in my June 2, 1994, letter.

4. EQUIPMENT REPLACEMENT: (MEDICAL)

Workgroup Recommendation

The amount of medical equipment replacement funds made available to each tribe is to be calculated on the basis of a formula that allocates 50% of the amount available based on the number of active users; 25% to those with hospitals; 15% to those with health centers; and 10% to those with health stations.

Director's Decision

I do not concur with the recommendation. Although equipment funds were distributed as recommended by the JAMW in 1994 and 1995, the Congress expanded the use of these funds, prompting review of the methodology. The IHS will use the recently developed formulae for distributing these funds.

The formula for distributing funds to existing tribal and IHS facilities ($10 million) is based on clinical workload (50%) and relative facility size (50%). The formula for distributing funds to equip new, tribally-constructed replacement facilities ($3 million) ranks all such facilities on the basis of relative space need, location, and extent that existing space will be used. Available funds will be allocated to the highest ranked (neediest) facilities, in priority order.

These formulae are a result of the congressional direction to develop a needs-based methodology for distributing funds made available to equip tribal replacement facilities constructed with non-IHS funds. That methodology and a companion methodology for distributing equipment replacement funds to existing tribal and IHS health care facilities were completed by a tribal/Federal workgroup.

5. EQUIPMENT REPLACEMENT (DENTAL)

Workgroup Recommendation

The dental equipment replacement funds made available to each tribe are to be calculated on the basis of a formula that allocates 50% of the amount available based on the number of active users; 25% to those with hospitals; 15% to those with health centers; and 10% to those with health stations.

Director's Decision

I do not concur with the recommendation. The IHS will discontinue the practice of establishing a discretionary dental equipment replacement pool. Beginning in FY 1996, any discretionary funds that would have been retained in Headquarters for this purpose will be distributed to the Areas in the annual Dental allocation.

6. ASSESSMENTS

Workgroup Recommendation

The IHS is to allocate the following resources and costs to the appropriate (organizational) level: Payroll, FTS, Rental of Office Space, Mailing Costs, and Employee Accident Compensation.

Director's Decision

I do not concur with the recommendation. The Agency would be placed at financial risk if the funds needed to pay the assessments were allocated below the Agency level. These costs are billed by various other Government agencies to the IHS Headquarters and the Agency is required to pay them centrally. If funds were not set aside in the resource allocation process, based on estimated requirements, the Agency would risk being anti-deficient, if it could not pay its bills. The IHS will continue to identify these costs on an Area and/or service unit basis so that management systems can be developed to better control and manage them. As these costs are reduced, the savings will be distributed to the Areas in the annual H&C allocation.

Workgroup Recommendation

A workgroup at the HHS/PHS level is to be formalized to: (a) examine the specific Assessment categories; (b) determine what resources should be allocated; (c) review the method and process to accomplish this allocation; and (d) develop an approach to protect the cost savings relative to downsizing. This workgroup should be composed of PHS, IHS, and tribal representatives. Proposed recommendations for transferring identified tribal shares should be completed prior to the start of 1996 Self Governance negotiations.

Director's Decision

I concur with the recommendation. I will request that the Assistant Secretary for Health establish a workgroup to review the other costs identified within the Assessment pool to determine if the charges are fair to the IHS and whether costs can be reduced. If costs can be reduced, these savings will be distributed to the Areas in the annual H&C allocation. This workgroup has yet to be established, therefore, the results will be unavailable for the 1996 negotiations.

7. SPECIAL PAY

Workgroup Recommendation

The current IHS reimbursement method and ISDM 85-4 are to be modified to include all categories of special pay, specifically incentive special pays. Additionally, these funds are to be allocated on a recurring basis directly to the service delivery site where the costs for compensation are incurred. This can be accomplished based on historical allocations after a 3-year period which would provide for an adjusted base to correct historical shortfalls caused by deficiencies in ISDM 85-4.

Director's Decision

I concur with the recommendation that ISDM 85-4 be revised to reflect the current special pay structure. The revision will also address identification of the funding source. The revised ISDM 85-4 will govern this process through FY 1996 to the extent that equivalent funds were not included in the base funding. Funds will be paid to contractors/compactors, on a reimbursable basis, for providers legally eligible for special pay to the extent that funds are determined available for this purpose.

8. PERMANENT CHANGE OF STATION (PCS)

Workgroup Recommendation

The PCS funds are to be made available as tribal shares based on 50% Active Users/25% Hospitals/15% Health Center/10% Health Station (with a differential to the Alaska Area).

Director's Decision

I do not concur with the recommendation. The IHS will discontinue the practice of reimbursing Areas and tribes for PCS from Headquarters maintained funds at the end of FY 1995. Beginning in FY 1996, funds for this purpose will be distributed to the Areas in the various program accounts. Costs for PCS will then be paid from locally available resources.

9. CONTINUING MEDICAL EDUCATION (CME)

Workgroup Recommendation

The distribution of the Continuing Medical Education fund is to be based on the number of eligible medical staff and that it be equal to reimbursement rates used by IHS for individual allocation as follows: $1,000/physician in the lower 48 states, $1,300/physician in Alaska; $500/dentist in the lower 48 states, $700/dentist in Alaska; and $200/nurse. Also that mid-level practitioners are to be eligible for continuing education reimbursements.

Director's Decision

I do not concur with the recommendation. Although the IHS will continue to advocate for an identification of CME funds for staff at the local level, the Headquarters fund will be discontinued at the end of FY 1995. Beginning in FY 1996, the funds will be distributed to the Areas as part of the overall allocation of H&C/program funds. The responsibility for assuming and for paying the cost of obtaining CME credits needed for staff accreditation will be paid by the Area/tribe with locally available resources.

10. RPMS/DATA PROCESSING

Workgroup Recommendation

The RPMS/Data Processing funds are to be distributed in accordance with the TSA methodology.

Director's Decision

I concur with the recommendation to distribute the RPMS/Data Processing funds using the TSA methodology. In concurring, however, it is critically important to both the IHS and all tribal programs to maintain an organization-wide system that supports the collective public health database from all AI/AN health programs.

Explanation of Decision

An information infrastructure is needed to support delivery of health care services, to provide collective data to advocate for resources, to improve management and efficiency, to support tribal management of programs, and to decrease the size of the

Agency, while maintaining the capability to fulfill all residual activities. We can work together to reduce administrative costs, while improving capabilities by implementing electronic commerce at all levels. We can open new channels of communications by implementing Government Information Locator Services and other customer services, and by taking advantage of advances in telemedicine. Perhaps most importantly, together we must reach out to our counterparts in education, economic development, land management, etc., to ensure that an Indian Information Infrastructure is implemented that supports the communities we serve.

Follow Up Actions

Opportunities for tribal participation in design, development, implementation, and support of Indian health information systems must be identified. The RPMS/Data Processing funds presently are used to maintain the centralized health statistical and patient care database; to support the development of RPMS software used at all tribal and IHS sites; and to support the design, testing, and maintenance of computer system platforms and the telecommunications network. Funds to purchase hardware for tribal and IHS facility operations are progressively more limited and new combined IHS/tribal initiatives must be developed to replace and upgrade existing systems.

11. MAINTENANCE AND IMPROVEMENT

Workgroup Recommendation

The use of the Oklahoma Formula is to be continued. Additionally, JAMW recommends revisions to M&I project guidelines by one or a combination of the following: (a) develop a priority funding formula for M&I projects which provides for a priority score adjustment based on continuous years of participation in the M&I competitive project pool; (b) limit selection to participate in the competitive pool versus selection of a tribe's share to either the initiation of the Self Governance compact or an open "enrollment" period once every 5-7 years; and (c) provide for "buy in" capabilities for Self Governance Tribes which have selected tribal shares and determine that they wish to re-enter the competitive pool.

Director's Decision

I concur with the recommendation to continue use of the Oklahoma Formula. I also concur with the need to establish controls over leaving and re-entering the pool of competitive M&I projects; therefore, I will establish a tribal/Federal workgroup to review the options presented along with the current methodology for the operation of the M&I pool.

12. HEALTH FACILITIES CONSTRUCTION

Workgroup Recommendation

The IHS is to work with tribes to seek a special line item appropriation for Self-Governance capital acquisition and construction which would permit participating tribes to draw down a negotiated tribal share. This approach could be on a pilot basis and could be phased-in.

Director's Decision

I do not concur with the recommendation. The IHS will continue with the June 2, 1994, position for Health Facilities Construction funds. The IHS distribution for health facilities construction is determined by congressional appropriations language and is project-specific based on the IHS facilities priority systems. The Congress directed development of and approved the IHS health facilities priority systems. Any revisions to these processes will need congressional approval. Regarding the proposed alternative for funding health facilities, IHS is continuing to discuss this matter with OMB and the Congress.

13. SANITATION FACILITIES CONSTRUCTION

Workgroup Recommendation

The IHS work with tribes to seek a special line item appropriation for Self-Governance capital acquisition and construction which would permit participating tribes to draw down a negotiated tribal share. This approach could be on a pilot basis and could be phased-in.

Director's Decision

I do not concur with the recommendation. The IHS will continue with the June 2, 1994, position for Sanitation Facilities Construction funds. The IHS distributes Sanitation Facilities Construction funds as required by the Indian Health Care Improvement Act. That distribution is project-specific, based on the extent of sanitation facilities deficiencies as defined in the Act. The IHS has explored alternative funding approaches and is responding, through OMB, to congressional questions about a variety of options.

14. OEHE SUPPORT

Workgroup Recommendation

The OEHE Support funds distribution is to be based on the TSA Method.

Director's Decision

I do not concur with the recommendation. The IHS position remains, as described in the June 2, 1994, response, that these funds should reflect workload distribution because they support activities funded by construction appropriations. A workload methodology ensures needs-based distribution of available funds.

15. ENVIRONMENTAL HEALTH SUPPORT

Workgroup Recommendation

The Environmental Health Support funds distribution is to be based on TSA Method.

Director's Decision

I do not concur with the recommendation. The IHS position remains, as described in the June 2, 1994, response, that these funds should reflect workload distribution because they support activities funded by the construction appropriations. A workload methodology ensures needs-based distribution of available funds.

16. FACILITIES SUPPORT

Workgroup Recommendation

The Facilities Support funds continue to be distributed based on current IHS workload methodology.

Director's Decision

I concur with the recommendation.

17. SCHOLARSHIPS/LOAN REPAYMENT

Workgroup Recommendation

The Scholarship/Loan Repayment funds continue to be administered by IHS and distributed based on the existing IHS methodology which is consistent with congressional intent.

Director's Decision

I concur with the recommendation.

18. TRIBAL MANAGEMENT GRANTS

Workgroup Recommendation

The Tribal Management Grant funds be distributed on a competitive basis.

Director's Decision

I concur with the recommendation.

April '95 Number 2

IHDT Update

Indian Health Design Team

Director Urges Expediency

Michael H. Trujillo, M.D., M.P.H., Director, Indian Health Service (IHS), addressed the Indian Health Design Team (IHDT) during its March 28 meeting. The following are excerpts from Dr. Trujillo's remarks.

I appreciate the committment which each of you made to participate in the IHDT and to help determine the future direction of Indian health programs. You have agreed to undertake a task which, under ideal circumstances, deserves more time than the Team has to complete it. However, every effort must be made to avoid being overtaken by external national forces responding to different priorities. To avoid this and to make sure that the recommendations which I must carry forward reflects Indian Country's priorities, I urge the Team to strive to complete the redesign plan in June as scheduled.

I am strongly committed to ensuring stakeholder involvement in the IHDT process because I attribute the Agency's strength to its partnership with Tribes, Indian health organizations and Indian people. The redesign of the Agency must involve the Tribes, Indian organizations and Indian people, as the principal stakeholders, from the beginning of the process. I want the changes proposed under the redesign to reflect Indian needs and priorities. I also would point out how Indian Country, the Administration and the Congress ultimately views the final proposal will be shaped and influenced by the knowledge that the principal stakeholders in the Agency played a significant role in the development of the new Agency design plan.

I want to update you on activities which are being undertaken by the Department of Health and Human Services (HHS) as the Federal government moves into the second phase of the Clinton Administration's Re-Invent Government Initiative (RE-GO II) and which will, I believe, affect Indian health programs. The Department is being challenged to develop more efficient ways of carrying out its responsibilities. For example, the consolidation of programs and decentralization of program activities to the field through the block grant mechanism is one of the options under consideration by the Department. The program consolidation and relocation to the field would require the redelegation of departmental authority to the agency level.

It is important to understand that the emphasis is on downsizing the Department with the goal of providing better service to our customers at lower costs to taxpayers. The Department has proposed Performance

(continued on page 2)

INSIDE

Director's remarks continued from page 1

Partnership Grants (PPGs) which would combine the existing Centers for Disease Control and Prevention (CDC) and the Sustance Abuse and Mental Health Services Administration (SAMHSA) grant programs into a single block grant program. States would administer the grant funds for state health initiatives which would be evaluated on specific health outcomes linked to the health objectives by the Federal government.

The HHSis also redefining its mission since the departure of the Social Security Administration (SSA) from the Department on March 31, 1995 makes the Public Health Service (PHS) its largest agency and reduced the HHS budget by 50 percent. In view of this major change, the Office of Assistant Secretary for Health may be eliminated. Proposals to convert this Assistant Secretary position into a staff position for the Secretary similar to an undersecretary position are being contemplated. While it is unclear how these Departmental changes may affect the legislative proposal to elevate the IHS Director to an Assistant Secretary level, the IHDT should still consider design options that, if necessary, prepares the Agency to report to the Secretary.

I have had a number of opportunities to testify before key Senate and House committees in the past two months. The message which I am hearing from the Congress is that the Federal budget will not be increasing and that, even under the best scenario, cuts as high as 10 percent are possible. As we all know, the Agency is already underfunded and I have made tribal consultation critical to any future decisions which affect our budget.

This is a time of change. Your work as a member of the Team is invaluable to enabling the Agency to continue its vital work on addressing the health care needs of Indian Country.

The Process is a Partnership

The process of designing a new Indian health system for the future is proceeding in partnership with all stakeholders--Tribal leaders, Indian people, and IHS employees. The Indian Health Design Team (IHDT) is composed of 28 members and 22 of them are tribal and/or urban representatives. Their role is to oversee and guide the design process to restructure the Indian Health Service (IHS) and design new capabilities needed for the future.

The members are following a two-tier approach to accomplish their charge. They have established a second level of workers called Tier II workgroups. Each of the six workgroups is exploring possibilities for change in operational aspects of Indian health care.

The Tier II workgroups are made up of 42 members representing a variety of experience. They are health care professionals and executives that serve Indian people from multi-levels of Indian health care program - - urban, federal direct, and tribal compacted/contracted.

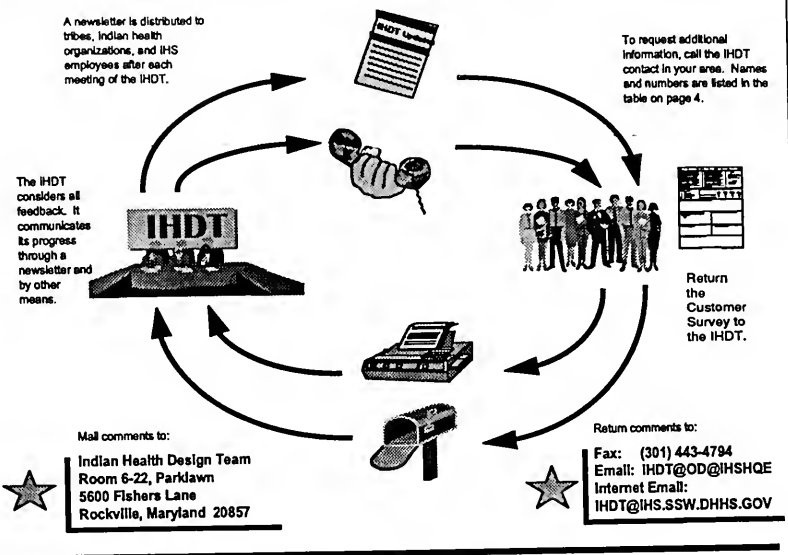
The two-tiered process provides a mechanism for two-way communication between the IHDT and the workgroups. Each workgroup has a liaison assigned to it who is a member of the IHDT. The workgroups develop possibilities for the IHDT to consider. After the IHDT reviews the possibilities, guidance is provided to the workgroups. The guidance may be for the workgroup to study an idea further, to focus its emphasis in a particular direction, or to abandon the idea completely. A description of some concepts formed by the Tier II workgroups are attached as a supplement.

Two-way communications have been established to link stakeholders to the IHDT for participating in the design efforts. The IHDT and its Tier II workgroup activities will be communicated to stakeholders through the IHDT Update newsletter; Congressional briefings; Tribal Leader letters; IHS Area Offices; the NIHB; and other major tribal organizations. The national Indian news media will receive the IHDT Update newsletter and may contact the IHS Office of Communications for additional media information packages.

People who have a stake in how the new IHS is designed can be involved by providing feedback to IHDT activities and by proposing new ideas for consideration. Stakeholders may contact Tier II workgroups (see supplemental pages for contacts); IHS Area Office IHDT Liaisons (see page 4); and Cliff Wiggins or Gayle Riddles in the Office of the Director, IHS. Mr. Wiggins and Ms. Riddles may be contacted on (301) 443-1083.

The members of the IHDT are opening two way communications between themselves and their partners in Indian Health.

(see chart on page 3)



Initial Design Concepts Offered

The Indian Health Design Team (IHDT) is moving to the next step in guiding the process for designing a new Indian health system. That step is for the IHDT to create, with the stakeholders in Indian health, a catalog of possibilities and concepts for designing an improved Indian health system.

The initial concepts were generated by Tier II workgroup members during their mid-March meeting. The IHDT discussed the initial possibilities and suggested some of them be explored further. These same concepts are being submitted to Tribal leaders to obtain their feedback and any additional ideas on the design efforts. The IHDT Co-Chairs, Ms. Julia A. Davis, Chair, National Indian Health Board (NIHB); Mr. Buford Rolin, Vice Chair, NIHB; and Mr. James Floyd, Director, Portland Area IHS, are notifying Tribal leaders about these initial design concepts through a Tribal Leader letter. See the attached supplemental pages for details about the initial concepts.

The Tier II workgroups are charged to assess possibilities for meeting the requirements for a new IHS. The concepts presented by the Tier II workgroups are not final and much more stakeholder feedback and staff work is needed before they will be ready for the IHDT's formal review. The IHDT plans to prepare a draft plan for designing a new IHS in June. The IHDT intends to have a refined draft ready for all stakeholders to review by August. Also, the draft will be submitted to others who have a significant stake in the IHDT's work including other federal agencies and the Congress.

The design concepts reflect six broad functional areas of providing health care to Indian people. These operational areas are self-determination and federal operations; clinical and public health operations; business/administrative/budget operations; workforce redeployment; information resources infrastructure; and Agency design, leadership, and advocacy.

The design concepts must respond to the variety of external factors affecting the delivery of care to Indian people. The entire health care industry is changing because of customer expectations and limited resources

to meet those expectations. The need for change is the result of a changing environment with new needs, new priorities, and reforms in state health and welfare that may affect eligibility for benefits. Some challenges facing the IHS and why it needs to be redesigned are: Congressional directives to restructure; reductions in the federal workforce; targets for all federal agencies to work better and cost less; transfer of programs to tribes through contracts and compacts; skyrocketing health care costs and advances in technology; and an increasing American Indian/Alaska Native population.

IHS Area Contacts

Contact persons listed below to request more information about Indian Health Design Team Events.

NAME	TITLE	ADDRESS	PHONE
Anthony Yepa	OTA Associate Director Albuquerque Area IHS	505 Marquette, N.W. Suite 1502 Albuquerque, MN 87102-2163	505/766-1546 505/766-2157 fax
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Gerald Ivey	Director Alaska Area IHS	250 Gambell Street Third and Gambell Street Anchorage, AK 99501	907/257-1153 907/257-1168 fax
Barbara Lahr	Program Analyst, PPES Bemidji Area IHS	127 Federal Building Bemidji, MN 56601	218/759-3432 218/759-3511 fax
Dr. Kermit Smith	Associate Director Billings Area IHS	2900 4th Avenue North Billings, MT 59101	406/247-7110 406/247-7230 fax
Allan Beckwith	Sr. Internal Auditor California Area IHS	1825 Bell StreetSuite 200 Sacramento, CA 95825-1097	916/566-7001 916/566-7053 fax 916/566-7020 Ext. 104 vm
Michael D. Tiger	Deputy Area Director Nashville Area IHS	711 Stewarts Ferry Pike Nashville, TN 37214-2634	615/736-2400 615/736-2391 fax
Peter Hoskie	OTA Associate Director Navajo Area IHS	P.O. Box 9020 Window Rock, AZ 86515-9020	*602 or 520/871-5814 *602 or 520/871-5896 fax *possible area code change
Luke McIntosh	OAM Associate Director Oklahoma City Area IHS	Five Corporate Plaza 3625 NW 56th Street Oklahoma City, OK 73112	405/945-3717 405/945-6870 fax
Mary Lou Stanton	Deputy Director Phoenix Area IHS	3738 North 16th Street Suite A Phoenix, AZ 85016-5981	602/640-2052 602/640-2557 fax
Dr. Clark Marquart	Chief Medical Officer Portland Area IHS	1220 S.W. Third Avenue Rm 476 Portland, OR 97204-2892	503/326-3900 503/326-7280 fax
John B. Narcho Charles Erickson	Executive Officer Tucson Area IHS Deputy Associate Director	7900 South "J" Stock Road Tucson, AZ 85746-9352 same as above	602/295-2406 602/295-2602 fax same as above

Initial Design Concepts from the IHDT

Clinical and Public Health

Workgroup Members

Francis Miguel (IHDT Liaison)
Council Woman, Tohono O'oham Nation

Doug Peter (IHDT Liaison)
Chief Medical Officer, Navajo Area

Andrew Montano
Executive Director, Albuquerque Area Indian Health Board

Brenda Gabbard
Director, Division of Nursing Services
Navajo Area IHS

Aaron Peters
Vice President, National Assoc. CHR
Director,KARUK CHR Program

Rita Harding
Area Nurse, Public Health Nurse
Billings Area IHS

Dave Baldridge
Executive Director
National Indian Council on Aging

Stan Griffith
Research Development Program

John Hamilton
OEHE, Phoenix Area, IHS

Carmelita Skeeter
Director,Indian Health Care Resource Center, Tulsa

Jonathan Sugarman
Pudget Sound Service Unit

Ken Peterson
Senior Clinician of Pediatrics, ANMC

Staff & Contact

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6A-30 Parklawn
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Rockville MD 20857

Phone: (301) 443-1106
Fax: (301) 594-6213

Or, contact the IHDT Liaison in your respective Area

Concepts

Local decision making model for public health systems design

1. Assessment of health status, needs, community desires.
2. Develop policies about what to do.
3. Assure services are accessible and acceptable.

Reduce Headquarters Professionals/Consultants

Fewer program consultants, reduce layers, downsize.
Pros: Maintains support at reduced levels, maximize $ for patient care.
Cons: Increased chance of loosing touch with field.

Decentralize Headquarters Professionals/Consultants

Redeploy program consultants to field.
Pros: Maintains support closer to field, maximize $ for patient care.
Cons: Possible conflicts in responsibilities (local versus regional).

Institute of Indian Health

Independent national organization without regulatory or enforcement role.
Pros: Objective, separate from Federal government with AI/AN expertise.
Cons: Funding requires cooperation. Might not be viewed as downsizing.

Smaller but same number of Area Offices

Downsized. Field support role rather than oversight. Organized functionally.
Pros: Reduce layers. Refocuses on field support. Maintains existing access.
Cons: Less downsizing. Reduced capacity. Functions lack critical mass.

Regional Offices by program type

Limited # for each type: federal, tribal, urban operations.
Pros: Consolidates; concentrates support on specialty; maximizes $ for services.
Cons: Program consultants are further from field.

Regional Offices by Geography

Limited # for each geographic region.
Pros: Consolidates; concentrates support capacity; maximizes $ for services.
Cons: Program consultants are further from field.

No Regional Offices (more autonomous local programs)

No Regional or Area Offices, all activities relate to national office (headquarters).
Pros: Maximum local control and flexibility, maximizes $ for services.
Cons: Small programs lack economies of scale.

Other concepts are possible and welcome.

Initial Design Concepts from the IHDT

Business, Administration, Budget

Workgroup Members

Richard Mandsager, Liaison to IHDT
Director, ANMC

Maggie Terrance, Liaison to IHDT
Health Director, St. Regis Mohawk

Tony Peterson
Executive Officer, Aberdeen Area

Arnold Leora
Clinical Director, Crownpoint Hospital

Carla Alchesay-Nachu
Director, Whiteriver Hospital

John Daugherty
Director, Claremore Hospital

John Foley
Budget Officer, Bemidji Area

Robert Clark
Chief Executive Officer
Bristol Bay Health Corporation

Ralph Forquera
Executive Director
Seattle Urban Indian Program

Staff & Contact

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Or, contact the IHDT Liaison in your respective Area.

Concepts

Customer Service Centers (CSC) in Area Offices

Area Offices (AOs) specialize. Serve service units (SUs) outside the Area.
Pros: Entrepreneurial. Offices SUs choice of service center. Builds on strengths.
Cons: Technology must be available. Some AO work force shifting/displacement.

Centers of Excellence (COE) in Neutral Locations

Specialized Service Centers at neutral sites. Serves SUs from many regions.
Pros: SUs choose COEs. Cost effective. Concentrates expertise.
Cons: Technology must be available. AO work force shifting/displacement.

Hybrids - Choose best source for each service

Each SU "Buys" from best source (SU, AO, COE, tribes, university, business).
Pros: Competition on cost. Downsize FTE. Flexible. Private sector expertise.
Cons: AO workforce displacement. Substantial change from existing systems.

National Institute of Excellence (collective buying service)

SUs, urban, tribes buy together from single best source.
Pros: Buying strength, leverage. Standardized process. FTE reductions.
Cons: Requires cooperation. Must create NIE. AO workforce displacement.

Contracted Support Centers (CSC)

Buy-Indian Service Centers are possible.
Pros: Similar to COE. Promotes AI/AN business opportunities. FTE reductions.
Cons: Availability of CSCs? AO workforce displacement.

Total Decentralization

All support functions and resources are delegated to SUs, urbans, contracts.
Pros: Maximum local $, independence, flexibility.
Cons: Lost $ economies. SUs must create capabilities. Workforce displacement.

Status Quo

Not major remodeling. AOs, SUs attempt to adapt independently.
Pros: No national decisions/consensus required.
Cons: No managed downsizing. Haphazard adjustment. Possible breakdowns.

Budget Simplification

Reduce and simplify multiple budget "lines" (e.g., to clinical, public health, tribal support). Tribal contractors now have budget flexibility. Flexibility is essential for local programs to be competitive and match to diverse community needs.

Other concepts are possible and welcome.

Initial Design Concepts from the IHDT

Self-Determination & Federal Operations

Workgroup Members

Dale Risling, Liaison to IHDT
Chairman, Hoopa Valley Tribe

Josephine Waconda, Liaison to IHDT
Director, Albuquerque Area

Jean Othole
Director, Zuni Hospital

Michael Tiger
Deputy Director, Nashville Area

Ron Demarey
Director, Administrative Services
Ramah Navajo School Board, Inc.

Rae Snyder
School Child & Family Counselor

Tim Martin
Tribal Administrator
Poarch Band of Creek Indians

Elva Siler
Indian Health Care Clinic
Salt Lake City

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Or, contact the IHDT Liaison in your respective Area.

Concepts

Congressional Appropriation Directly to Tribes

Appropriations are made directly to Tribes. May include a simple dispersing office.

Headquarters Issues Self/Determination Contracts & Compacts

Regional Offices Issue SD Contracts and Compacts

Area Offices Issue SD Contracts and Compacts

Service Unit Issue SD Contracts and Compacts

Federal SUs given authorities similar to SD Contractors/ Compactors

Authorities to function with maximum local flexibility and responsibility are delegated to the lowest possible levels.

All operational authorities are delegated to Area Offices

All operational authorities are delegated to Regional Offices

Other concepts are possible and welcome.

Initial Design Concepts from the IHDT

Information Resources Infrastructure

Workgroup Members

Taylor Satala
Chairman, Hoopa Valley Tribe
Liaison to IHDT

Fran Miller
Executive Director,
American Indian Health Care Assoc.

Ed Mouss
Director, Dept. of Public Health
Creek Nation of Oklahoma

John Yao
Chief Medical Officer
California Area

James Garvie
Acting Deputy Associate Director
Office of Information Resources, IHS

Doni Wilder
Executive Director
NW Portland Area Indian Health Board

Frank Sutton
Director, Hospital Services
SEARHC Mt. Edgecombe Hospital

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Phone: (301) 443-1064
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Or, contact the IHDT Liaison in your respective Area.

Concepts

Create Capabilities for a "Virtual Indian Community"

A powerful telecommunications network that interconnects all tribes, IHS, urban, and Indian health organizations. Allows maximum flexibility to access information and services from anywhere within the system.

Incremental Change and Status Quo

No systematic reconfiguration of existing IHS, tribal, urban information capabilities. System adapts or is replaced according to the independent choices of Service Units, tribes, or urban programs.

Define Necessary Capabilities

The workgroup will identify the new functional capabilities that will be needed under various proposed reconfigurations of Indian health programs. It will consider how small tribes and SUs will be assured access to new capabilities.

Investment Costs & Strategies

The workgroup will estimate relative costs, necessary investments for various scenarios, and strategies for financing needed investments.

Joint IHS/Tribal/Urban Master Plan

The workgroup will evaluate existing capabilities considering various reconfiguration scenarios. It will propose alternative ways of supplying capabilities -- joint I/T/U development, purchase off-the-shelf, contracting services.

Value

The workgroup will consider the value of new technologies. These include lowering costs, increasing efficiencies, generating revenue, enhancing buying power, and offering advanced capabilities to Indian country.

Other concepts are possible and welcome.

Initial Design Concepts from the IHDT

Work Force Redeployment

Workgroup Members

Gary McAdams
President, Wichita Tribe, Oklahoma
Liaison to IHDT

Robert McSwain
Associate Director,
Office of Human Resources, IHS
Liaison to IHDT

Jack Markowitz
Acting Deputy Assoc. Director
Office of Admin. and Managemen, IHS

F. Dale Keel
Assoc. Dir., Health Program Services
Oklahoma Area

Charles North
Clinical Director
Albuquerque Hospital

Loretta Bad Heart Bull
Director, Educ. & Training
Black Hills Training Center

Eugene Trottier
Indian Health Board of Billings

Russ Alger
Director
Warm Springs Indian Health Center

Will Scott or Barbara Davis
Personnel Managment Specialist, IHS

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Or, contact the IHDT Liaison in your respective Area.

Concepts

Phasing

Planning workforce deployments must be phased to follow restructuring proposals that are accepted.

Workforce Assumptions

IHS federal workforce will be reduced by 1,000 FTE over 5 years (15,000 to 14,000.) Additional 1,000 FTE is needed to fully staff new/replacement hospitals and clinics. Redeployment plans will be necessary.

Simplification

The workgroup will propose options to simplify and expedite personnel actions that are necessary to adapt and manage the workforce in a reconfigured health care system.

Workforce Composition

The workgroup will propose options to adapt the composition of the workforce (e.g., mix of primary care professionals, mid-levels, reductions in supervisors, mix of administrative support employees, etc.) to meet new configurations.

Redeployment Tools

The workgroup will identify tools (authorities, methods, waivers, etc.) that will be necessary to accomplish redeployment of the workforce.

Regional Offices by program type

Limited # for each type: federal, tribal, urban operations.
Pros: Consolidates, concentrates support on specialty, maximizes $ for services.
Cons: Closing some Area Offices, program consultants are further from field.

Employee Transition Issues

The workgroup will identify ways to accomplish transition with minimal disruption and assure fair treatment of all employees. Identify training, counseling, competency, reassignment prospects, etc.

Focus on Customer and Cultural Competence

The workgroup will identify ways to orient the work force to be "customer centered" with particular emphasis on competency for the cultures of the tribe and communities that are served.

Other concepts are possible and welcome.

Initial Design Concepts from the IHDT

Agency Leadership, Advocacy

Work Group Members

Julia Davis
Chair, NIHB
Liaison to IHDT

Marjorie Bear Don't Walk
Executive Director, Indian Health Board of Billings, Liaison to IHDT

(Membership is not yet finalized. The workgroup has not met officially. Elected tribal officials will be included in the membership.)

Contact Point

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Staff

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Or, contact the IHDT Liaison in your respective Area.

Concepts

Contributed Ideas

This workgroup has not yet met to officially begin deliberations. The following concepts were offered by others and have not been considered by the workgroup.

Streamlined Headquarters, No operational responsibilities

Institute for Indian Health

Quasi-Independent Organization with not regulatory or operational function. Primary purpose would be advocacy and expertise in Indian health.

Consolidation of Indian programs within HHS

Increased Affiliation with BIA for Administrative Functions

Other concepts are possible and welcome.

Initial Design Concepts from the IHDT

Mission Reveiw IHDT Sub-Group

Mission Review Subgroup Workgroup Members

Mary Beth Skupien (IHDT Liaison)
Office of Health Programs, IHS

Deanna Bauman (IHDT Liaison)
NIHB & Oneida Nation of Wisconsin

Jeannie Lunsford
Cherokee Nation of Oklahoma

Clark Marquart
Portland Area IHS

Richard Church
Office of Information Resources Management, IHS

Carol Marquez
Indian Health Board of Minneapolis

Linda Colangelo
Navajo Area IHS

Norine Smith
Indian Health Board of Minneapolis

Brian Myles
K.E.M.C.

Staff & Contact

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Concepts

Current IHS Mission Statement

To provide a comprehensive health services delivery system for American Indians and Alaska Natives (AI/AN) with opportunity for maximum tribal involvement in developing and managing programs to meet health needs.

Proposed IHS Mission Statement

The mission of the IHS is to raise the health status of the AI/AN people to the highest possible level.

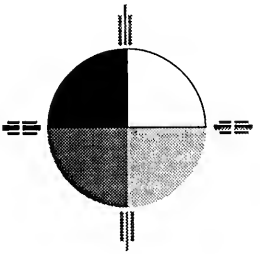
Current IHS Goal Statement

To raise the health status of the AI/AN people to the highest possible level.

Proposed IHS Goal Statement

To assure that comprehensive health systems are available to provide accessible, acceptable services, in partnership with AI/AN. This goal is founded on the Federal government's obligation to honor, uphold, protect, and advocate for the inherent sovereign rights of AI/AN Nations.

Designing a new Indian Health Service



IHDT Update
April '95, Number 2

DEPARTMENT OF
HEALTH & HUMAN SERVICES
Room 6-22
Public Health Service
Indian Health Service
Rockville, MD 20857

LUMMI INDIAN BUSINESS COUNCIL
2616 KWINA RD. • BELLINGHAM, WASHINGTON 98226-9298 • (206) 734-8180
DEPARTMENT: _____ EXT. _____

June 12, 1996

Dr. Michael Trujillo, Director
Indian Health Services
Public Health Service, Department of Health and Human Services
Room 6-05, Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

RE: 1996 Self Governance Negotiations - Request for Meeting June 22 or 23, 1995

Dear Dr. Trujillo:

Several of the Self-Governance Tribes held a one day meeting last week in Spokane, Washington to discuss the problems and unresolved issues that have been experienced by each of us during the current 1996 negotiations process. As a result of this meeting, I am writing on behalf of these, and all other Self-Governance Tribes, to respectfully request a meeting with you to be held on either Thursday, June 22, or Friday, June 23, 1995 in Rockville, or, at a location convenient to you.

As Tribal leaders, we request this meeting with you to discuss and offer recommendations in order to reach resolution on the major outstanding issues related to the 1996 Self-Governance negotiations. The timing of this meeting is critical to Tribal fiscal year negotiations, which are to be concluded by the June 30, 1995 deadline. These issues and concerns are as follows:

- The 1996 AFA Negotiations Process including the lack of authority of the Lead Negotiators and the appeals process;
- Designation of significant Headquarters programs and line items which were identified as not available for Tribal Shares, without any explanation/negotiation;
- Contract Support Policy for both 1995 and 1996 has yet to be finalized;
- Process for establishment of Tribal Base Budgets;
- Proposed IHS/SG Guidelines Circular; and,
- Development of a Tribal consultation process as an alternative to the current IHS/Tribal Workgroup System

All of these concerns were raised by Tribal Leaders with IHS senior staff during the pre-negotiation meeting in Reno in March of this year. However, these issues continue to persist. Self-Governance Tribal Leaders had hoped that the negotiations for the 1996 Annual Funding Agreements would be a step towards stability in the IHS relationship, but this has not been the case. Unfortunately, policy confusion and the active resistance of IHS staff that has marked the 1995 Self-Governance implementation process, thus far, will continue into 1996 and undoubtedly will continue beyond 1996 unless the support you have personally expressed and demonstrated for Tribal Self-Governance truly becomes IHS policy and is evident in IHS actions.

Therefore, with the agitated agreement of the Tribal leadership assembled in Spokane, on June 7, 1995, we have advised all IHS Self-Governance Tribes not to sign their 1996 Annual Funding Agreements until these issues have been resolved to their satisfaction. We believe that these issues have not and cannot be satisfactorily resolved through the negotiation process. We believe that only your personal intervention will be adequate.

We are confident that under your leadership and commitment to the Self-Governance process, we can successfully proceed in advancing the goals and future of this historic initiative. This meeting is an essential step in exercising our government-to-government relationship in the negotiation process and is consistent with both the goals of Self-Governance and with the Presidential Executive Order issued last year as a result of the commemorable meeting between Tribal Leaders and President Clinton.

In order to allow time to arrange for travel and meeting logistics, your immediate response is greatly appreciated. Please contact me directly at 360/ 304-2229 or C. Juliet Pittman, 202/ 628-1151, regarding your availability for either of these dates. Thank you for your serious consideration of our request.

Sincerely,

Henry Cagey

Henry Cagey, Chairman
Lummi Indian Nation

cc: The Honorable Donna Shalala, Secretary, Department of Health & Human Services
Dr. Philip Lee, Assistant Secretary for Health, Public Health Service
Ms. Jo Ivey Boufford, Principal Deputy Assistant Secretary, Public Health Service

[illegible]

United States Senate

COMMITTEE ON INDIAN AFFAIRS
WASHINGTON, DC 20510-6450

May 5, 1995

The Honorable Michael Trujillo, MD
Director
Indian Health Service
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, Maryland 20857

Dear Dr. Trujillo:

We are writing to provide you with a series of questions in follow-up to the Committee's May 2nd oversight hearing on the implementation by the Indian Health Service (IHS) of the Tribal Self-Governance Project.

1. In presenting the testimony of the Indian Health Service, Mr. Michel Lincoln indicated that the IHS does not intend to negotiate any additional Self-Governance Compacts in fiscal year 1996 despite the change in law authorizing up to 30 additional compacts each year, beginning with 1996. The Committee is advised that letters of intent to enter into Compact negotiations were sent to certain tribal governments and that planning grants were made available to prepare those Tribes for the compact negotiation process.

   (a) Given the expectations that such actions on the part of the Indian Health Service have engendered, and the reliance the affected Tribes have placed on IHS actions, what is the basis for imposing a moratorium on any new compacts in fiscal year 1996?

   (b) If more compacts were added in 1997, will a priority be extended to those Tribes that have expended considerable time, energy and resources in preparing themselves to enter into compact negotiations in fiscal year 1996 based upon their reliance on representations made by the Indian Health Service?

2. We have just begun the eighth month of the fiscal year and Tribes inform the Committee that IHS has yet to distribute any of the negotiated tribal shares of Headquarters and Area Offices.

   (a) Why have you delayed the transfer of these funds?

(b) When will these dollars be made available to tribal governments?

(c) What steps have been taken to ensure that delays in the transfer of funds associated with the allocation of negotiated shares are not repeated in future years?

3. The Committee has heard from Tribes who strongly oppose the recent IHS decision to refuse payment of contract support funds to cover tribal indirect costs associated with administering tribal shares of Area and Headquarters accounts.

(a) Once a Tribe has negotiated an indirect cost rate with the Office of Inspector General, what legal authority does IHS have to fund some shares and not others?

(b) Has IHS considered downsizing its administrative staff in order to fully fund its contract support obligations to Tribes operating programs under Titles I and III?

4. In our February budget hearing, you testified that IHS was going to "redeploy" 176 FTE positions from existing operations to staff new health facilities.

(a) How do you respond to tribal assertions that such a redeployment will reduce IHS-supported staff at the service units of other Tribes.

(b) Will shift staffing funds out of the reach of the Self-Governance negotiations of those other Tribes?

5. The Committee has received complaints from Tribes that their negotiations with IHS have been frustrated and lengthened by the fact that key IHS decision-makers are not at the table. What will you do in the pending negotiations for fiscal year 1996 to ensure that the IHS negotiators at the negotiation table have full authority to evaluate the tribal negotiation positions first-hand and respond with appropriate adjustments to the IHS negotiation positions?

6. For nearly two years, Tribes trying to access the IHS "active users" data base used to develop tribal shares have said the IHS system loses data Tribes put in, or it scrambles the data in a manner that makes the data highly unreliable. What is IHS going to do to make this system useful to Tribes and when do you intend to do this?

7. The Committee is advised that the Department has kept away from the negotiation table a 35-million-dollar "administrative assessments" account, although the law clearly requires IHS to make available for tribal share negotiations all funds related to the provision of services to a Tribe, including Federal administrative costs. The Congress expects IHS administrative costs for payroll, rent, supplies, and telephones to be reduced as Tribes

assume more of these responsibilities, and expects funds which were previously expended at the federal level to be transferred to the Tribes.

(a) Will the Department negotiate tribal shares of this 35-million-dollar account as required by law for fiscal year 1996?

(b) If not, under what legal authority does IHS withhold these funds?

(c) What steps have you already taken with the Public Health Service and the Department to initiate the workgroup you mentioned will be studying this administrative assessments account?

(d) When will its review and recommendations be completed?

(e) Will its recommendations be applied to fiscal year 1996 negotiated agreements?

8. We all recognize that the need for Indian sanitation and health facility construction is fast outpacing the availability of appropriated funds.

(a) Has IHS developed any other financing options which could leverage private financing or provide for lease purchase arrangements and thereby begin construction that could be paid for over time? If so, please provide the Committee with a detailed description of these various alternative methods.

(b) What steps has IHS taken to involve Tribes in the development of alternative financing methods?

9. Reinvention and other down-sizing efforts are affecting IHS. The Congress has always expected IHS to reduce its operations to reflect the transfer of functions, services, activities and services to Tribes under Self-Governance. Please provide the Committee with specific examples of how the IHS has been correspondingly reduced in size and shape after a Tribe has taken over responsibilities that the IHS had previously undertaken for the Tribe?

10. We are informed that the Nashville Area Office has led Tribes to believe that it will refuse to negotiate and fully fund tribal shares in fiscal year 1996. What specific action are you taking to require Area Offices to both negotiate and fully fund tribal shares for fiscal year 1996?

11. The Committee is advised that the Office of General Counsel has issued another opinion that continues to interpret the statute to intend the anomalous result that a Tribe may

contract under Title I for the management of construction activities but may not Compact under Title III to manage such construction activities. Please provide the Committee, either from your office or the Office of General Counsel, with specific statutory language which would authorize a Tribe to manage such construction activities and to administer all other IHS programs and functions under a Title III Compact.

12. During the past 24 months, on what dates did IHS request and receive reduction-in-force authority and how many FTE's per year does IHS plan to reduce in fiscal years 1995, 1996, and 1997 to free up funds to help pay Title III and Title I tribal shares?

13. Does IHS plan to fully fund all Area and Headquarters tribal shares in fiscal year 1996? If not, what level of tribal share funding is IHS planning to make available and what is the legal authority for this proposed position?

The Committee would appreciate a response to the questions set forth above in a timely fashion. The Committee has yet to receive responses to the written questions that the Committee forwarded to the Indian Health Service on February 14th, immediately following the Committee's hearing on that date. The Committee's obligations require that we receive timely responses to questions, and we are thus seeking your personal oversight to assure that responses are provided in a timely manner.

Sincerely,

JOHN McCAIN
Chairman

DANIEL K. INOUYE
Vice-Chairman

Testimony
of the
Cherokee Nation
on
Tribal Self Governance
of Indian Health Service Programs
presented by
Pamela E. Iron, Executive Director
Cherokee Nation Health Services Division
before the
Senate Committee on Indian Affairs

May 2, 1995

Mr. Chairman and Members of Committee: Greetings from Chief Wilma Mankiller, Principal Chief of the Cherokee Nation. It is an honor for me to speak on behalf of Chief Mankiller and to represent Cherokee Nation before this Committee. We appreciate the opportunity to discuss the positive benefits that the Indian Health Service ("IHS") Self Governance Demonstration Project has had on Cherokee health care and other important issues related to Indian health care delivery.

I. *Permanent Self Governance Legislation for IHS*

Almost no issue is of greater importance to Cherokee Nation than Indian health care delivery and proper implementation of our Self Governance Compacts. With over 160,000 members we are the second largest tribe in the United States and the largest tribe to negotiate Self Governance Compacts, first with the Department of Interior in 1990 and then with the Department of Health and Human Services in 1993. Under both compacts, Cherokee Nation has accepted major responsibilities for the operation of Indian programs and for the proper expenditure and accounting of federal resources provided through our self governance compacts. We can say proudly that self governance has been a major success for us. We invite you to visit Cherokee Nation to observe our operations and witness our successes in the Cherokee homeland in northeastern Oklahoma

As an example of how self governance is being implemented by Cherokee Nation, I would point to our Cherokee Rural Health Network. Our health network is the first tribal health network established in the United States utilizing managed care concepts in redesigning health care systems under self governance. The Cherokee Nation Rural Health Network integrates health care and specialty services provided by our tribally-operated clinics with the health programs conducted by the federally operated IHS hospitals in eastern Oklahoma. The Wilma P. Mankiller Health Center, a new 35,000 outpatient facility dedicated on April 29, 1995, is an important component of the network. We want to thank this Committee and especially Senator Nickles for his assistance in obtaining the funding and naming of this facility.

The decision of Congress to amend the Indian Self Determination and Education Assistance Act (P.L. 93-638) by adding the Self Governance Demonstration Project Act was a crucial step in strengthening the government-to-government relationship between the United States and Cherokee Nation. We believe the most significant feature of self governance is the tribes' ability to decide for themselves how to structure their programs, set their own priorities in

light of each tribe's own special needs and problems, and more appropriately and efficiently deliver services to tribal members. While our Department of Interior self governance programs are of a wide variety, our Indian health programs have one primary goal: furnishing quality health care services to Indian people, *our Indian user population.*

Despite the successes and accomplishments of the IHS self governance programs within Cherokee Nation, we feel there are still some people at all levels of IHS who do not take the program seriously because it is not a permanent part of the agency. This attitude, at times, results in lack of cooperation in the implementation of the health programs assumed by Cherokee Nation under its compact and annual funding agreements with the Department of Health and Human Services. We believe that self governance within IHS has been a "demonstration project" long enough. It is now time for Congress to make it a permanent program just as Congress did for programs administered by the Department of Interior.

Permanent implementation of the IHS Self Governance Program should be a high priority of the federal government. Chief Mankiller and Cherokee Nation are grateful to you, Mr. Chairman, to Senator Inouye, and the Committee for your dedication to this program and we will do everything we can to persuade the Clinton Administration to support prompt enactment of permanent legislation.

II. *IHS Administrative Funding Allocation Formulas*

Critical to successful continuation of Indian health care delivery through the IHS self governance program is retention of proper funding allocation formulas. However, on April 18, 1995, the IHS Director announced a decision that is adverse to most of IHS users in Oklahoma and in the United States. Public Law 93-638, as amended, allows tribes the option of receiving all of the funding the "Secretary" would have had to operate the programs, including a share of "Central Office" funds. The IHS Director announced adoption of a new allocation formula called the "Tribal Size Adjustment" formula, rather than the historical formula based on active-user population. Shifting to this new formula will divert Central Office funding from tribes with IHS user populations of more than 1,500 to those with fewer than 1,500 users. Oklahoma has several tribes with more than 1,500 users. The proposed new formula would benefit only 4% of the IHS users in Oklahoma and cause adverse impact on 96% of the users. Nationally, the new formula would result in 90% of the IHS users receiving less funding for their tribes.

A comparison of the Tribal Size Adjustment formula and the 100% Active Users formula clearly shows the advantage of using the 100% Active User Formula. **Analysis shows that 89.73% of users would receive more resources using the 100% Active User Formula.** Defenders of the Tribal Size Adjustment (which now includes a "modified 30/70 formula") have never adequately justified its use or explained why it is superior to, say a 5/95 or a 10/90 ratio. They simply say that this variation of the 30/70 type formula would fund the infrastructure and fixed costs necessarily incurred in any service program regardless of the size of the user population it serves.

At Cherokee Nation and many other self governance tribes, resources made available to tribes as "tribal shares" of IHS headquarters and Area Offices have been used for additional direct health care services or for the direct health care delivery system for the Indian people. Historically, these funds have been justified and set aside by IHS for specific programs or

purposes designed to serve "user populations." To be consistent with IHS policy, in selecting any funding allocation formula, the first and most important consideration should be the impact on the entire IHS user population. Resource allocation methodologies must be both equitable and rational, with primary attention given to delivering quality health services to eligible users of IHS services.

The principles of Self Governance as dictated by Title III of P.L. 93-638 require that tribes entering the program be qualified and have a demonstrated capacity to participate in the Self Governance Program. Nevertheless, some small tribes contend that they need additional resources to establish an infrastructure and administrative base. Yet, all potential self governance tribes have an operational base consisting of 638 contract funding (or its theoretical equivalent) and its associated indirect cost funding. Therefore, by design all Self Governance tribes necessarily have a funding base and a demonstrated capacity to conduct IHS programs and activities. Any extra funding to make up for small size would not be necessary funding -- it would be extra funding!

Adoption of the Tribal Size Adjustment Formula represents a departure from the emphasis on user population as a basis for allocating resources in favor of the aforementioned "Tribal Size Adjustment Formula". Under this new formula, a portion of the funding is allocated by tribe, generally regardless of the size of its user population, and the balance of the funds is allocated based upon user population. The use of this method or any similar method for determining tribal shares will result in a radical reallocation of IHS funds away from eligible users who are members of large tribes, like Navajo Nation and Cherokee Nation, and toward the support of bureaucracies of certain tribes with very small user populations. The larger the tribe, the greater the impact will be on its user-members, given that per capita funding will decrease greatly as user population increases. Thus, the Tribal Size Adjustment formula will benefit a relatively small percentage of the total IHS user population at the very considerable expense of Indian people who are members of large tribes.

Adoption of the "Tribal Size Adjustment Formula" also would be an unfortunate policy and philosophical shift in the way IHS allocates resources. The new formula would set aside a portion of funds once dedicated to direct Indian Health care services, in order to finance instead the building and maintenance of government "infrastructure" for the smaller tribes.

We ask that this Committee review this critical funding issue and include in permanent legislative language directing that any funding methodology for the distribution of IHS Central Office Tribal Shares be allocated based upon the user population to be served. IHS funding should be applied so as to *make all eligible Indian people more healthy*, not their tribal bureaucracies.

Furthermore, Cherokee Nation is emphatic that any funding allocation formula for any program for Native Americans -- block grant or otherwise -- must be justified and based on active user population served by the program.

III. ***IHS Appropriations***

Another advantage of self governance and the allocation of "tribal shares" of IHS administrative funding to meet specific health requirements is that the tribe can increase funding

for health care delivery, without an increase in appropriations. This does not mean, however, that IHS funding can or should be rescinded or reduced! What we need is more efficient use of IHS funding, not a reduction of funding.

Here we wish to express our sincere appreciation to Chairman McCain for his successful effort to restore IHS funding in the face of significant cuts proposed for IHS in the initial FY 1995 budget. While we understand that the current fiscal environment will again impose considerable constraints on FY 1996 discretionary spending, the federal government must demonstrate its continued commitment to tribes by providing sufficient funding for IHS operations.

Now it is all the more important to remind the Appropriations Committees that the unmet need for Indian health services remains at approximately 30% of funds required. With this enormous unmet need, there should be no reductions in overall Indian health care funding. The IHS has too long existed with funding levels far below demonstrated need. To impose any additional reductions would result in a disproportionate share of budget reductions taken by IHS -- whose mission is to discharge the federal trust responsibility to Indian people by providing direct health care services to eligible Indian users -- compared to other federal agencies, most of which have merely a regulatory mission.

Full funding of contract health care is particularly essential. I mentioned earlier our Cherokee Rural Health Network. This Cherokee Nation self-governance initiative has expanded the primary care rural health network to include specialty care provided on a contract basis by 90 private physicians and local hospitals. The network has over 95,000 users, making ours the largest of all tribal health care delivery systems with over 150,000 outpatient visits in 1994. Sadly contract health care denials in Oklahoma continue to rise, and worse still, new funds appropriated have not been distributed to the Cherokee region. In fact, the additional 1995 contract health care funds have not been distributed to any IHS Area or to self governance compacts.

Cherokee Nation has requested that the Interior Appropriations Subcommittees focus on the urgent funding needs of IHS. Among Cherokee Nation's particular requests is the addition of $1 million to the Hastings Service Unit budget for in-patient contract health care services to improve in-patient care and specialty services.

We would greatly appreciate strong support for IHS funding from members of this Committee, especially Senators Gorton, Domenici and Reid, who also serve on the Senate Interior Appropriations Subcommittee.

IV. *FTE Reductions*

While on the IHS budget, we offer some comments regarding FTE reductions. A ten-year old General Accounting Office study, updated for inflation, reported that it would cost about $36,300 to terminate the employment of a typical federal worker today, compared to a maximum of $25,000 (before taxes) buy-out payment. Therefore, we recommend that FTE ceilings not be reduced any further than present levels and that, for IHS to meet its target, it be given buy-out authority for a two-year period. Large reductions in the federal workplace of hands-on providers will have a detrimental impact on delivery of health services to Indian

people. We also propose that FTE's working directly for tribes through IPA's and MOA's be allocated to a tribal FTE pool and be free from all FTE reductions or ceilings, especially since costs for salaries of these positions are covered by the operational funds provided to tribes.

V. ***Compacting Operation of Multi-User Facilities***

Currently under Title III, compacting for the operation of certain IHS facilities may be complicated if IHS takes the position that the facility is a "multi-user" operation that benefits members of more than one tribe. Our own experience in this regard has been exceedingly frustrating. Cherokee Nation has proposed to construct an expansion building for W.W. Hastings Indian Hospital in Tahlequah, Oklahoma. However, the Oklahoma Area Office has taken the position that the Indian hospital benefits more than one tribe simply because the Service Unit boundary includes a clinic operated by another tribe -- even though that clinic is not served by the Hastings Indian Hospital. We feel that this type of unanticipated problem can be solved by creating an effective and practical test to define "multi-user" so that no undue obstacles are presented when tribes seek to compact facility operations in the future. We would be happy to work with your staff to address this issue through either legislative or regulatory change.

VI. ***Construction Contracts***

The IHS reluctance to embrace the self governance project is evidenced by its interpretation of federal laws in ways that sometime block a tribe's efforts at full implementation of its compact. Just one example is a years old opinion of the Office of General Counsel that self-governance tribes were not protected by the Federal Tort Claims Act provisions of P.L. 93-638 because "compacts" were not "contracts" under that law. This opinion caused considerable alarm among IHS self governance tribes and their professional health care personnel, forcing the tribes to go to Congress for a corrective amendment

A similar situation has arisen in the area of construction contract management. Again, the Office of the General Counsel issued an opinion stating that, while tribes can contract under Title I of P.L. 93-683 to perform construction contract management, they cannot compact under Title III to do the same service. The OGC opinion contended that the level of federal oversight necessary for construction of federal facilities is inconsistent with the Self Governance Demonstration Project Act's goals of tribal independence in decision making. This opinion leads to the absurd result that tribes can perform these services under Title I but not Title III.

Therefore, we ask the Committee to include a provision in permanent IHS self governance legislation that authorizes self governance tribes to compact construction project management.

VII. Conclusion

Thank you again, Chairman McCain, Senator Inouye and other Committee members, for this opportunity to present the views and concerns of Cherokee Nation. We have enjoyed a close working relationship with the Committee in past years and look forward to working with you and your staff in the future to implement the Self Governance Program with IHS on a permanent basis.

Cherokee Nation Opinion
Indian Health Service
Funding Allocation Methodologies

On April 18, 1995, the Director of the Indian Health Service announced a decision that is adverse to most of Indian Health Service users in Oklahoma and in the United States. Public Law 93-638 as amended allows tribes the option to assume the major responsibilities and control for the operation of the Indian programs of the Bureau of Indian Affairs and the Indian Health Service. Along with this responsibility the tribes have the option of receiving all of the funding the "Secretary" would have had to operate the programs and this would include a share of "Central Office." The Director of the IHS announced a decision to use a formula called "Tribal Size Adjustment," which is further described below. The use of this formula will shift Central Office funding from tribes with IHS user populations of more than 1,500 to those with less than 1,500. Oklahoma has a number of tribes with more than 1,500 users. The current proposed formula will benefit only 4% of the IHS users in Oklahoma and cause adverse impact to 96% of the users. Nationally the formula will result in 90% of the IHS users receiving less funding for their tribes.

Resources made available to tribes as "tribal shares" of IHS headquarters and Area Offices have been used for additional direct health care services or for the direct health care delivery system for the Indian people. Historically, these funds have been justified and set aside by IHS for specific programs or purposes designed to serve "user populations." To be consistent with IHS policy, in selecting any funding allocation formula, the first and most important consideration should be the impact on the user population. Resource allocation methodologies must be both equitable and rational, with primary attention given to delivering quality health services to the user population.

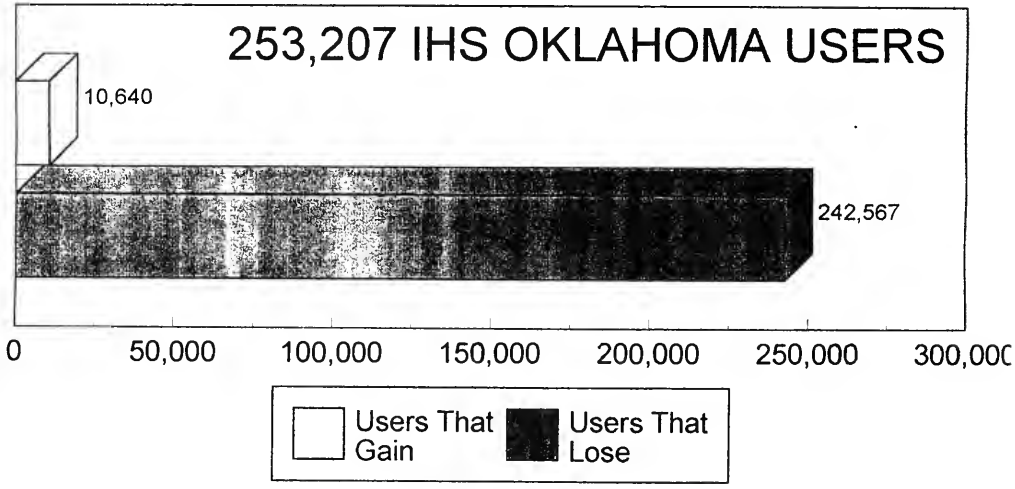
The principles of Self Governance as dictated by law require that tribes entering the program be qualified and have a demonstrated capacity to participate in the Self Governance Program. It was not designed to develop tribal government infrastructures or bureaucratic capacity. Still, some small tribes contend that they need a base. All tribes have an operational base consisting of 638 contract funding (or its theoretical equivalent) and its associated Indirect Cost funding. Therefore, all Self Governance tribes must necessarily have a funding base and a demonstrated capacity to conduct IHS programs and activities. Any extra funding to make up for small size would not be necessary funding – it would be extra funding.

Many small tribes or groups of small tribes are now advocating a departure from the emphasis on user population as a basis for allocating resources in favor of a modified "30/70" type formula known as Method C, Tribal Size Adjustment, whereby a portion of the funding is allocated by tribe, generally regardless of the size of its user population, and the balance of the funds are allocated based upon user population. The use of this method or any similar method for determining tribal shares would result in a radical reallocation of IHS funds away from eligible users toward the support of bureaucracies of certain small tribes: the larger the tribe, the greater the impact on its user-members with per capita funding decreasing as user population increases. Thus, the Tribal Size Adjustment and the

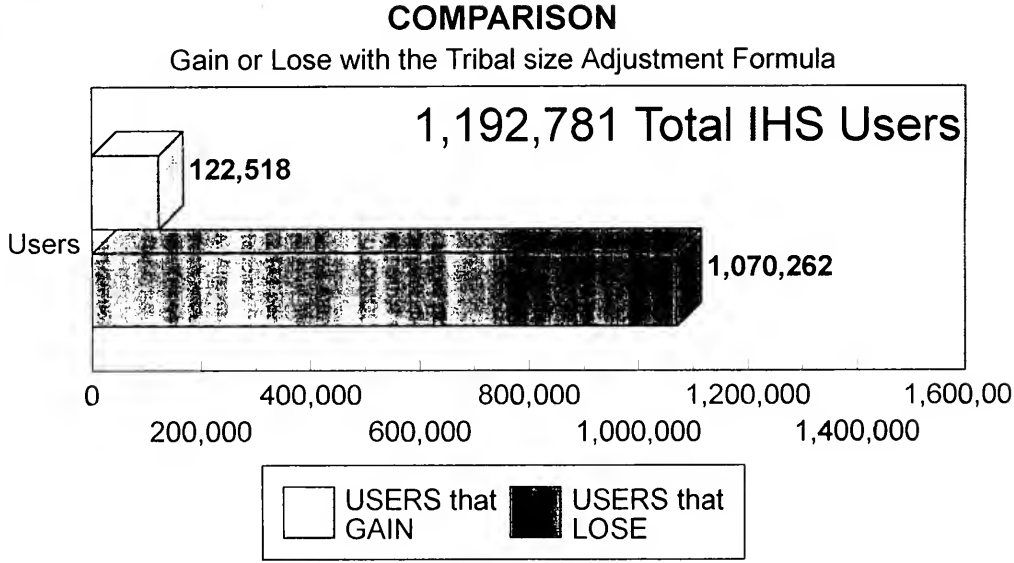
30/70 formulas would benefit a relatively small percentage of the total IHS user population at the very considerable expense of Indian people who happen to be members of large tribes. Adopting the Tribal Size Adjustment or 30/70 formula would also represent a philosophical shift in the way IHS allocates resources, by setting aside a portion of funds once dedicated to direct Indian Health care services to finance instead the building and maintenance of government "infrastructure" for the smaller tribes.

A comparison of the Tribal Size Adjustment formula and the 100% Active Users formula clearly shows the advantage of using the 100% Active User Formula. Analysis shows that 89.73% of users would receive more resources using the 100% Active User Formula. Defenders of the Tribal Size Adjustment or 30/70 formula have never adequately justified its use or explained why it is superior to, say a 5/95 or a 10/90 ratio. They simply say that a 30/70 type formula would fund the infrastructure and fixed costs necessarily incurred in any service program regardless of the size of the user population it serves.

TRIBAL SIZE ADJUSTMENT vs. 100% USER FORMULA EFFECT ON OKLA. USERS



TRIBAL SIZE ADJUSTMENT vs. 100% USER FORMULA EFFECT ON ALL IHS USERS



Facts about the IHS "Adjusted User Formula"

- **4.2% of the Oklahoma IHS Area users benefit from the use of this formula.**
- **95.8 % of the Oklahoma IHS Area users do not benefit from the use of this formula. 95.8% of the Oklahoma IHS Area users would receive more funding if the 100% User formula was used.**
- **10.27% of the 1,192,780 users benefit from the use of this formula.**
- **89.73% of the 1,192,780 IHS users do not benefit from the use of this formula. 89.73% of the 1,192,780 IHS Users would receive more funding if the 100% User formula was used.**
- **$7.3 Million will be shifted from tribes with more than 1,500 users to tribes with less than 1,500 users.**
- **$1.4 Million will be shifted away from Oklahoma.**
- **53.95% of the funding shifted from large tribes to small tribes will go to Alaska. Of the $7.3 Million shifted to smaller tribes, $$3.9 Million will go to Alaska.**

  Alaska does not, in actual practice, operate as 240 small tribes. Health Care is delivered by 11 Organizations. In DOI Self Governance Alaskan Consortiums get ONE tribal share. Why would they ask for a small tribe benefit? " MORE FUNDING!"

  FY 1994 Final Resource Allocations indicate major discrepancies in funding different areas of the country. Alaska Area's FY 94 funding for the 93,722 users was $2,141 per user or $1,811 per user (reduced by the 25% cola), while the Oklahoma Area FY 94 funding for its 257,421 users was only $767 per user. Alaska, before the cola adjustment, received an amount per user which was 2.36 times greater than Oklahoma Users. And now the Alaskan Tribes are proposing additional allocations' be made for Alaska. Is this fair?

- **JAMW (Final Report 1/26/95), page 10, lists the main reason given for the 30/70 formula and the Tribal size Adjustment (Base/Active Users) formula. "This distribution formula provides a base to smaller Tribes for fundamental governmental responsibilities" is the only reason stated.**

The law requires that tribes entering the Self Governance program be qualified and have a demonstrated capacity. Self Governance was not designed to develop a tribal government infrastructure or bureaucratic capacity. Tribes do have a base. Tribes have an operational base consisting of 638 contract funding and its associated Indirect Cost Funding.
Use of the Tribal Size Adjustment Formula would allocate extra funding to small Tribes and take away funding from large tribes. Large Tribes need extra funding, too.

- The small tribes state that their recommendation for the Tribal Size Adjustment formula is a COMPROMISE. The Webster's Dictionary 10th Addition lists the definition of compromise as:

    1. A settlement of differences by consent reached by mutual concessions, or

    2. A concession to something derogatory or prejudicial.

  In this case there is no mutual consent and the result of the formula would not be derogatory, since additional funding would go to them, therefore there is no compromise.

- The JAMW workgroup membership was small tribe prejudiced from the beginning.

  The 5 IHS members, formerly participated in the IHS internal workgroup which developed the "30/70" formula. It appears to us that these individuals came to this workgroup to promote the "30/70" formula, not to develop a fair and equitable distribution formula. Also, except for one member, the IHS representatives all came from IHS Areas which mainly represented small tribes (one of the IHS representatives was from Alaska).

  Tribal representatives, including the workgroup Tribal Co-Chair were from small tribes. The Tribal Co-Chair represented a small tribe that has actively lobbied for the use of the 30/70 formula. Alaska had two tribal representatives who actively lobbied for more funding for Alaska. The majority of the tribal membership represented small tribes.

  The result of this workgroup membership - a formula that would benefit small tribes and Alaska, at the expense of large tribes.

Question - Would the Workgroup recommendations have been the same if the membership had been fairly and evenly distributed between large and small tribes? I think not.

- The IHS Co-Chair of the Workgroup forced a recommendation into the final JAMW Report.

The tribal representatives had previously decided to present all of the options for funding formulas, with no recommended formula. The report was to remain neutral. This was presented to the Tribal leadership at the NIHB meeting in November 1994. The Tribal leadership agreed to this format.

The IHS Co-Chair was able to force the workgroup to vote on a recommendation, at the last meeting. With the IHS representatives, several small tribes and the Alaska vote, the vote for a recommended formula was forced.

The report is now prejudiced. The recommendation is a reflection of the make up of who the workgroup members represent and not technical.

- The Tribal Caucus, held in February, was unfair.

The Caucus was called, arranged and coordinated by the tribes advocating the Tribal Size Adjustment Formula.

Each tribe was afforded 1 vote, regardless of the number of users served. NCAI long ago recognized the fact that this was unfair and adopted voting practices to account for tribal size.

Of the 236 tribes voting in favor of the Tribal Size Adjustment Formula, 190 were from Alaska.

The 236 tribes voting in favor of the Tribal Size Adjustment Formula represented less than 130,000 users or 10.9% of the total 1,192,180 thousand IHS Health users.

The 15 tribes voting against the Tribal Size Adjustment Formula represented almost 500,000 users or 40% of the total 1,192,180 users.

United States Senate

COMMITTEE ON INDIAN AFFAIRS
WASHINGTON, DC 20510-6450

May 5, 1995

Ms. Pamela Iron
Executive Director
Health Services Division
Cherokee Nation of Oklahoma
P.O. Box 948
Tahlequah, Oklahoma 74465

Dear Ms. Iron:

We are writing to provide you with a series of questions which arose during our oversight hearing on May 2nd on the implementation by the Indian Health Service of the Tribal Self-Governance Project.

1. Your written testimony indicates a strong preference for allocating tribal shares based on number of Indian users without any adjustment for the size of a Tribe's operation. As a relatively large Tribe, would you please cite some examples of why administrative or programmatic costs are not lower than those of smaller Tribes on the basis of economies of scale.

2. Have you made any effort to secure a reconsideration by the IHS of what you have termed the "absurd result" of its lawyer's advice that a Tribe can manage the construction of a facility under a Title I contract but cannot do so under a Title III Compact? And if so, what was the response of the agency to your efforts?

Thank you again for appearing before the Committee. Your testimony was most helpful to the Committee and we look forward to your additional responses to these questions.

Sincerely,

JOHN McCAIN
Chairman

DANIEL K. INOUYE
Vice-Chairman

CHEROKEE NATION

P.O. Box 948 • Tahlequah, Okla. 74465-0948 • (918) 456-0671

Wilma P. Mankiller
Principal Chief

John A. Ketcher
Deputy Chief

July 10, 1995

Honorable John McCain, Chairman
Senate Committee on Indian Affairs
Washington, DC 20510-6450

Honorable Daniel K. Inouye, Vice-Chairman
Senate Committee on Indian Affairs
Washington, D.C. 20510-6450

Re. IHS/Self-Governance--allocation of tribal shares, construction activities under Title III vs. Title I of P.L. 93-638

Dear Senators McCain and Inouye

Let me begin by thanking you for providing me with the opportunity to testify before the Committee during its May 2nd hearing on IHS self-governance programs. With over 160,000 tribal members, Cherokee Nation is by far the largest of all tribes participating in self-governance under Title III ("IHS") and Title IV (Interior) of the Indian Self-Determination and Education Assistance Act, as amended ("ISDEA").

Generally speaking, our experience with self-governance and our relations with IHS and BIA in connection with implementing our self-governance programs have been positive and rewarding. Despite the often wrenching changes that have swept through these federal agencies as a result of self-governance, the increase and expansion of Title I contracting, and the new drive to reduce the size of federal government coming from within the Administration and from the Congress, most officials within IHS and BIA have shown us a willingness to negotiate compacts and annual funding agreements in good faith and to resolve, on a government-to-government basis, a wide range of difficult issues which have arisen in the course of implementing our self-governance programs.

That is not to say, however, that we have not encountered problems.

Following the Committee's May 2nd hearing, you wrote and asked for further information on two specific issues raised in my written testimony (a copy of your letter is enclosed for your convenience) First, you requested that I explain how administrative or "programmatic" costs are not lower for larger tribes than for smaller tribes due to economies of scale Second, you asked whether we have made any effort to secure reconsideration by IHS of the legal opinion from the Office of General Counsel ("OGC") which stated, in effect, that a tribe may contract for construction of federal facilities under Title I but not Title III of the ISDEA

Please note that after receiving your letter, the Director of the Cherokee Nation's legal division, David Mullon, traveled to Washington and met with Diane Humetewa in the Committee's offices on June 7, 1995, to present our position on various issues, including those raised in your May 5th letter to me With respect to the first issue, the tribal share allocation formula, as Mr Mullon pointed out to Ms Humetewa, in adopting the "Tribal Size Adjustment Formula," which reserves an extra portion of the IHS headquarters budget for distribution to tribes with small user populations, Dr Trujillo must have assumed that all or most large tribes have highly centralized administrative and programmatic health service delivery systems which would enable them, through the "economies of scale," to reduce costs and operate more efficiently than small tribes The problem with this assumption is that the actual geographic and demographic circumstances of a large tribe's health service system may render this assumption false.

Cherokee Nation's health care delivery system is a case in point As you can see from the enclosed maps of our territorial area, Cherokee Nation operates five clinics located in five different counties in northeastern Oklahoma Although it is true that some of our administrative health staff work in the tribal complex in Tahlequah, each of the five clinics has, as it must, its own administrative and programmatic staff, since all are located great distances from each other and many miles from the tribal complex (The clinic nearest to the complex is the Wilma P Mankiller Health Center in Stilwell, about 30 miles away, and the farthest, in Nowata, is about 105 miles from the complex) These five health centers serve about 100,000 Indian people, Cherokee and non-Cherokee alike, who are dispersed over a territorial area of some *9238 square miles* Many of these people reside in remote, sparsely populated areas, or in the numerous small Indian communities wedged deep in the hill country of eastern Oklahoma

Perhaps the so-called "economies of scale" apply to large health care systems structured and operating under ideal circumstances Unfortunately, our own health care system must operate within the geographic and demographic realities of Cherokee Nation Our clinics are outposts of health care, strategically located so as to reach a widely dispersed, rural population of eligible users Five clinics require five separate staffs of administrative, professional and clerical personnel, each must be furnished, equipped and maintained separately None are located near major metropolitan areas or airports The road and highway system here is mediocre at best, and

often very poor Access to our health care facilities is always an issue, especially for older tribal members.

As a consequence of these and other inherent problems, it is conceivable that some small tribes, those whose populations are concentrated in the vicinity of an Indian health center or hospital, would enjoy far greater administrative and programmatic economies than does the Cherokee Nation.

In fairness to Dr. Trujillo, many tribal representatives advocated another version of the Tribal Size Adjustment Formula, one which would have diverted an unconscionably large set-aside from the tribal shares of tribes with large user populations for redistribution to tribes with small user populations. Dr. Trujillo rejected this version of the formula on grounds of equity, and we commend him for a decision which he considered fair but which he must have known would invite intense criticism. Still, the approved formula will have a substantial funding impact on tribes serving large user populations. We feel that the only rational *and equitable* formula is the one based strictly on the tribes' user populations, the formula used in fiscal years 1994 and 1995.

If unavoidable factors such as the number of eligible users, or the inherent geographic, demographic or any other *demonstrated* inefficiency of a health care system, render a particular tribe's operations (large or small) more costly, the tribe should receive additional funding from a special congressional appropriation earmarked for the specific purpose overcoming such inefficiencies; a tribe should not receive such additional funding by way of an "appropriation" by the IHS from the tribal shares of large tribes. The United States government alone bears the responsibility of adequately funding Indian health care for all tribes. Shifting part of this responsibility to large tribes through an allocation formula which merely redistributes a finite and insufficient resource does nothing but pit large tribes against small tribes and diverts attention away from the fundamental problem--Indian health care is and always has been inadequately funded.

With respect to your second question regarding the OGC opinion (to the effect that tribes may contract to construct federal facilities under Title I but not Title III of the ISDEA), we have had ongoing discussions with the IHS Office of Self-Governance regarding this opinion and its effect on a particular project we would like to include in our current fiscal year annual funding agreement. However, we do not expect that OGC will alter its opinion or that IHS will refuse to follow OGC's advice.

For your information, there have been two OGC opinions on this issue, one in August of 1993 and another in April of 1995 (copies of which are enclosed). The second opinion was issued after complaints by self-governance tribes (including Cherokee Nation) that the earlier, 1993 OGC opinion was little more than a shield thrown up to protect another IHS function from compacting

under Title III It came as no surprise to Cherokee Nation that the 1995 opinion reached essentially the same conclusion as the 1993 opinion [1]

Both of these OGC opinions completely ignore, *never even mention*, the express mandate in section 303(e) and (f) of Title III that "to the extent feasible" federal laws and regulations be interpreted to facilitate compacts and to include of IHS "activities, programs, services and functions" in the self-governance compacts, but instead do just the opposite interpret federal laws and regulations so as to frustrate compacting of IHS activities, programs, services and functions The basic argument that OGC makes in the 1993 opinion is that construction of federal facilities requires extensive federal oversight as a matter of law, more oversight than the underlying policies of Title III self-governance will tolerate, so that this particular activity is off-limits to Title III compacting

The reasoning behind the opinion is both flawed and patronizing The opinions is flawed for the reason that section 303(a)(6) requires the Secretary of Health and Human Services to provide funding in the annual funding agreement for programs, services, functions or activities, "in an amount equal to that which the tribe would have been eligible to receive under contracts and grants under this Act " Nowhere in Title III is there any language which would suggest that some Title I contract activities are inappropriate for Title III agreements

Assuming for the sake of argument that federal construction projects require, as a matter of law, as much federal oversight as OGC contends (and we feel that this point is more than just a little overstated in the opinions) the policies of self-governance would hold that the tribe, and not OGC, should decide whether it wishes to take on an activity or project which requires federal oversight If the tribe decides that it can accept the federal supervision, then it should be allowed to include the project among its other compacted programs and activities

In fact, compacting activities which require some federal oversight, supervision and/or presence are a commonplace Cherokee Nation, for example, engages in many activities on trust land which, under the National Environmental Policy Act ("NEPA"), require an environmental assessment to determine whether an environmental impact statement is necessary Cherokee Nation engages in scoping, public comment, site analysis and assessment, and then drafts an

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[1]The April 1995 opinion is extremely confusing It states that funding for a federal construction project may be "identified" in a Title III annual funding agreement, but that this funding must be obligated, funded and expended pursuant to Title I of ISDEA and in accordance with a Title I contract The 1995 opinion fails to state why funding "identified" in a Title III agreement must also be tied to a separate Title I contract, no authority is cited for this proposition nor any explanation given as to why a Title III agreement could not be used to cover the entire transaction We are left to speculate that OGC believes that the rationale behind the 1993 opinion, discussed below, also justifies the conclusions of the 1995 opinion

environmental analysis ("EA"). Under NEPA, however, as a matter of law, only a federal official can make a "Finding of No Significant Impact," so this is done by an official within the BIA after reviewing the tribe's EA and other documentation. This entire process is conducted under, and funded through, Cherokee Nation's Title IV self-governance compact with the Department of Interior. (There are many other examples—such as our tribal land leasing program or our IIM account management activities.) It would seem that OGC would exclude these other activities from Title III compacting as well due to the element of federal oversight.

In my written testimony before this Committee, I stated that OGC's position on this issue leads to an absurd result, that a construction project may be contracted under Title I but not Title III. I feel my statement was accurate. What OGC has done is to take the principles of self-governance and turn them into a sword—to fight self-governance. We feel that it is important that the Committee be made aware of this barrier to implementing self-governance within IHS.

Again, I thank the Committee for this opportunity to express my views.

Sincerely,

Pamela E. Iron

Pamela E. Iron
Executive Director, Health Programs

PI lwh
Enclosures

cc: Wilma P. Mankiller, Principal Chief
David A. Mullon Jr., Director, Law & Justice

DEPARTMENT OF HEALTH & HUMAN SERVICES

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August 24, 1993

TO : Michel E. Lincoln, Acting Director
Indian Health Service

FROM : Barbara Hudson, Attorney
Office of the General Counsel

SUBJECT: Request for Opinion 93-86: Facilities Construction Programs Under Self-Governance

In preparing for the implementation of Title III of the Indian Self Determination Act, you have asked our opinion on the following questions.

1. May IHS waive the Federal Acquisition Regulations (FAR) for construction projects in Title III compacts?

Your question assumes that Title III compacts and funding agreements will be used to define the relationship between IHS and a tribe for discrete Federal construction projects, e.g., construction of an IHS hospital or outpatient facility. However, we do not view the construction of a Federal facility as appropriate for inclusion within a compact or funding agreement. This would include sanitation facilities constructed under Pub. L. 86-121 authority and later transferred to a tribe under that authority. While Indian tribes may contract under the Indian Self Determination Act (ISDA) for discrete construction projects including clinic and sanitation facilities, there is nothing in Title III that changes what is essentially a procurement relationship between the IHS and the tribe for construction of discrete Federal projects.

To answer your specific question, we do not believe that IHS has any additional waiver authority with respect to the FAR under Title III compacts than it does under Title I contracts. With respect to the construction of Federal facilities, the contracting officer's responsibility is an inherently governmental function which must be performed by an official of the Executive Branch of the United States. The Office of Management and Budget (OMB) issued a policy letter that sets forth the functions which must be performed by Government employees. According to the policy letter, "[a]n inherently governmental function involves, among other things, the interpretation and execution of the laws of the United States so as to: (a) Bind the United States to take or not to take some action by contract ...." Further, Appendix A of the policy letter lists the awarding,

administering, and terminating of contracts as examples of inherently governmental functions. (57 Federal Register 45096 - 45103 (1992).

Moreover, the legislative history surrounding the enactment the 1987 amendments to the ISDA recognized that certain Secretarial functions could not, as a matter of law, be contracted or performed by non-government employees. The original drafts for the 1988 amendments to ISDA proposed expanding the Secretary's authority to contract "any and all of the functions, authorities and responsibilities of the Secretary of Health and Human Services under the Act of August 5, 1954." S. Rep. 274, 100th Cong. 1st Sess. 71 (1987). However, prior to final enactment of the 1988 amendments, the above language was deleted based on legal and constitutional questions raised by the Department of Justice. The Department of Justice concluded that the proposed language was in serious tension with the constitutional doctrine of separation of powers and, in particular, with the Appointments Clause of Article II, Section 2, Clause 2. Under the U.S. Constitution, a person who exercises "significant authority pursuant to the laws of the United States" is an "Officer of the United States", and must, therefore, be appointed in the manner prescribed by the Appointments Clause. Buckley v. Valeo, 424 U.S. 1, 126 (1976). Representatives of tribal organization obviously are not appointed as principal officers by the President with the advice and consent of the Senate, or as inferior officers by the President alone, the Courts of Law, or the Head of a Department, as provided for by that clause. Thus, the Secretary of HHS, who is an Officer of the United States, may not enter a compact which divests the Secretary of inherently governmental functions.

In conclusion, we believe that Title III compacts may appropriately be used to plan, conduct, consolidate, redesign, and administer programs but not for a discrete construction project. A Self Governance (SG) Tribe may continue to use the Title I authority to apply for a construction contract. Under section 105(a), the Secretary continues to have authority to waive certain FAR provisions which he or she determines are not appropriate for the purposes of the contract. However, we find no legal basis which would permit the Secretary to enter a compact for the construction of a Federal facility thereby waiving the contracting officer's inherently governmental function related to construction.

2. May the requirements of the Davis-Bacon Wage rates be waived by the Secretary or the Self-Governance Tribe for construction, maintenance, and improvement projects in Title III compacts?

Clearly, section 7, which describes the Davis-Bacon wage requirements, applies to construction contracts under Title I. As discussed above, we do not view the construction of a Federal facility as appropriate for inclusion in a compact or funding agreement. Moreover, even if compacts were used for construction, we believe section 7 of ISDA would apply to such compacts.

In answer to your question, we find no authority for the Secretary to waive section 7 or the Davis-Bacon Act. However, it is important to note that there is an exception to the application of the Davis-Bacon Act to tribal governments. Under the Davis-Bacon Act, the Solicitor of Labor concluded that States or political subdivisions of States are not, as prime contractors, bound by the prevailing wage requirements of the Act. This exception has been interpreted to include force account labor of Indian tribal governments and tribal governmental instrumentalities.

3. May we assume that Self Governance tribes assume all legal responsibilities for obtaining clearances and have obligation for environmental compliances, handicapped access compliances, energy conservation compliance, etc?

As previously indicated in opinions from this office (see attached opinions by Lindsay Naas), the FAR governs all Federal construction contracts. As described in the attached opinions, responsibilities for obtaining clearances and compliance with Federal and State laws continue to be an IHS responsibility.

4. May IHS require SG tribes to sign an assurance for compliance?

See answer to question 3.

5. May IHS require the SG tribes to sign the compact with this requirement?

See answer to question 3.

6. Are the compacts authorized by Title III considered "contracts" or "grants", or neither?

Although not specifically applicable under section 9 of ISDA, the Federal Grant and Cooperative Agreement Act of 1977, 31 U.S.C. 6301, et seq., provides a good point of reference for defining the three basic types of legal instruments which the government uses to transact business. They are a procurement contract, a grant, and a cooperative agreement.

A procurement contract is defined as an instrument used to acquire property or services for the direct benefit or use of the United States Government. 31 U.S.C. 6303. A grant is an instrument between the Federal Government and a non-federal entity when the principal purpose of the relationship is to transfer a thing of value to the recipient to carry out a public purpose and no substantial continuing involvement of the United States is expected in carrying out the activity covered by the grant agreement. 31 U.S.C. 6304. A cooperative agreement is a legal instrument which is used between the Federal Government and a non-federal entity when the principal purpose of the relationship is to transfer a thing of value to the recipient to carry out a public purpose of support or stimulation authorized by law, and substantial involvement is expected between the United States and the recipient in carrying out the agreement. 31 U.S.C. 6305.

Often agreements between governments are referred to as compacts. These compacts contain characteristics of both a contract and a grant. According to the Supreme Court, compacts have many of the indicia of contracts, i.e., they contain legally binding rights and obligations for the two governments. (Texas v. New Mexico, 482 U.S. 124, 128 (1987).) While a compact may be a type of contract, we note that it is not a procurement contract because it is not a contract for the procurement of goods and services for the United States. Further, while a compact has many of the indicia of a contract, it also has characteristics similar to an assistance relationship, e.g., grant, in that IHS has little continuing involvement with the Tribe as it carries out the programs under the compact.

In summary, while compacts have characteristics similar to both grants and contracts, a compact has its own unique authority under Title III of the ISDA which essentially establishes a demonstration program.

I hope this information is helpful to you. If you have any questions, please feel free to contact me at 301-443-1212.

Barbara Hudson

Attachments

contract for the "initial project activities", or 37.58% of the total program, the available base funding would have been $30,506 for fiscal year 1990. Under section 106(a)(2) of the Act, contract support costs would be added to the base amount determined under section 106(a)(1).

CONCLUSION

The requisition, cost estimate, and inspection activities of the SFCB program (or essentially all of the activities related to management of the actual construction contracts) are effectively required by the FAR to be conducted by federal employees. Thus, MITC's proposal that a tribally employed Field Engineer would serve as the technical representative for the government COR and would monitor project activity cannot be approved. The remaining portion of the SFCB program may be assumed under a Self-Determination Act contract.

Under section 106(a)(1) of the Act, the base funding available for this program for fiscal year 1991 will be the amount determined by the RRM to be available for the Kincheloe SFCB program, plus project support funds, multiplied by the percentage of total SFCB activities to be contracted. Under section 106(a)(2), contract support costs would be added to the base funding amount. The IHS may retain the portion of base funding available for the program commensurate with the portion of SFCB program activities retained.

Lindsay Naas

Lindsay Naas

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April 17, 1995

TO : Michael H. Trujillo, Director
Indian Health Service

Barbara Hudson, Attorney
Office of the General Counsel

SUBJECT : Construction and Title III of the Indian Self Determination Act (ISDA)

This memorandum is in response to your request that we review our former legal opinion, dated August 24, 1993. You ask if funds appropriated for constructing health care facilities may be included in an Annual Funding Agreement (AFA) under Title III? Initially, the question appears relatively simple and straightforward. However, we must consider, not only whether funds may be included in an AFA, but the law governing the obligation and expenditure of such funds. For example, does including construction[1] funds in an AFA change the relationship between the tribe and the Federal government? In other words, is a tribe permitted to take over all Federal functions related to the direct Federal construction of a facility[2] simply because it has funding in its AFA? Alternatively, may the tribe use the construction funds in an AFA for the construction of a tribal facility under tribal procurement rules? To answer these questions, we examine decisions of the comptroller general with regard to improvement of property and the construction authority of the Indian Health Service (IHS).

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[1]The word construction, as used in this opinion, also includes design.

[2]When the term direct Federal construction is used in this opinion, we mean the construction of a facility with Federal funds and, upon completion, title to such facility belongs to the Federal government. The term Federally assisted construction means any construction involving Federal funds in which the final ownership of the facility does not reside with the Federal government.

Self Determination Act (ISDA)(Public Law 93-638)[7], and the Indian Sanitation Facilities Act (ISFA)(Public Law 86-121)[8] with respect to construction of sanitation facilities projects.

II. IHS CONSTRUCTION AUTHORITY

A. APPROPRIATION ACT

The Appropriation Act authorizes the expenditure of funds for construction of health care and related auxiliary facilities as authorized by the Indian Self-Determination Act (Pub. L. 93-638) and the Indian Health Care Improvement Act (IHCIA)(Pub. L. 94-437)[9] and for the construction of sanitation facilities for Indian homes and communities as authorized by the Indian Sanitation Facility Act (ISFA)(Pub. L. 86-121). Therefore, we must consider what these laws authorize with respect to construction.

B. SECTION 102 of ISDA

Section 102 of Title I of ISDA authorizes IHS to enter into contracts with tribes for the construction of Federal facilities.[10] The Indian Self Determination Act Amendments of 1994[11] made significant changes in Title I of ISDA. First, section 105(a), as amended, states that Federal contracting laws do not apply to contracts entered under section 102 of ISDA. Second, the applicability of the Federal Acquisition Regulations (FAR) is restricted and subject to negotiation between the parties. Third, section 106(f), as amended, states that title to a Federal facility used in connection with a section 102 self-determination contract for health services vests with a

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[7] 25 U.S.C. 450 et seq.

[8] 42 U.S.C. 2004a.

[9] 42 U.S.C. 1601 et seq.

[10] We note that section 9 permits the IHS to use a grant under section 102 in lieu of a contract.

[11] Pub. L. 103-413, 103rd Cong., 2nd Sess. (1994)

tribe unless the tribe requests otherwise. However, the title is subject to a reversionary interest in the event of retrocession, recision, or termination of the ISDA contract or grant.

Thus, IHS has statutory authority to contract with Indian tribes under Title I of the ISDA for direct Federal construction projects. However, because the above sections specifically relate to contracts under section 102, we do not believe that they are applicable to Title III compacts.

C. SECTION 103 of ISDA

Section 103(b) authorizes IHS to make grants to tribes for the construction of health care facilities.[a] Title to a facility constructed under a grant generally remains with the grantee. While section 103 authorizes grants, the Public Health Service (PHS) has maintained a policy that grants under ISDA will not be used to construct facilities. However, this decision is a matter of agency policy and it is our understanding that IHS has requested a review of this PHS policy.

We note that section 105(a), which waives Federal contract and cooperative agreement laws, does not waive Federal grant laws.[b] In the event that PHS permits IHS to use its authority to make grants for construction, it is important for IHS and the grantee to review the Federal requirements related to construction grants including requirements for Federally assisted construction. Listed below are some of the Federal requirements that we believe are applicable to section 103 grants:

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[a]Such facilities may be characterized as Federally assisted construction.

[b]One might argue that this omission simply was an oversight on Congress' part. However, the legislative history does not support such a conclusion. The Senate bill, which became Pub. L. 103-413, at one time contained language which would have made Federal grant laws inapplicable to section 103 grants. (S. Rep. 103-374, 103rd Cong., 2nd Sess. 1994, 1994 LEXIS, Legis library, Cmtrpt file.) Because such language was removed prior to enactment, there is strong evidence that Congress did not intend to waive Federal grant requirements.

42 CFR Part 36, Subpart H--Grants for Construction,

Chapter IV of the PHS Grants Administration Manual (GAM) on requirements for construction grants,

Part 140 of Chapter I of the PHS GAM on protecting the Federal interest in real property acquired with grant funds,

PHS Grants Policy Statement (especially note Appendix 2),

HHS published guidelines for Federally assisted construction (HHS Technical Handbook, February 1994), and

45 CFR Parts 74 and 92.

D. SECTION 303 of ISDA

Section 303(a)(1) of Title III authorizes the Secretary to enter into AFAs with tribes for the administration of activities, programs, services, and functions. We believe that this language is broad enough to include taking over a Federal construction function. However, if Federal construction is a function that a tribe may take over under Title III, a question naturally arises as to what is the relationship between the tribe and the IHS with respect to carrying out the Federal project. Simply identifying funds in an AFA does not change the fact that it is direct Federal construction.[14]

While funding could be identified in a Title III AFA for use under a Title I contract or grant, we find nothing in Title III which would change or override other law related to direct Federal construction. Thus, the construction would be carried out under the provisions and authority of a Title I contract or grant.[15]

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[14]As discussed below, IHS may not contract for inherent Federal functions.

[15]As noted herein, by virtue of section 105(a), the applicability of Federal Acquisition Regulations to construction contracts is restricted and subject to negotiation between the

E. Indian Sanitation Facilities Act (Pub. L. 86-121)

In addition to the authority of ISDA, the appropriation act authorizes construction funds to be used under the authority of Pub. L. 86-121, the Indian Sanitation Facilities Act.[14] The ISFA authorizes IHS to construct sanitation facilities "by contract or otherwise" and to make "such arrangements and agreements" with tribes regarding contributions toward the construction as are equitable and will best assure future maintenance of facilities. This authority has been interpreted to give the IHS broad discretion in choosing methods of providing sanitation facilities.

Currently, construction of sanitation facilities is accomplished through an agreement authorized under Public Law 86-121 which sets forth the scope of work and method of accomplishing the work. We believe that funds may be identified in an AFA under title III for construction of sanitation facilities. However, as previously discussed, simply identifying funds in an AFA does not change the fact that it is Federally assisted construction under ISFA. As such, funds would be obligated and expended under an agreement authorized under the ISFA as currently is the practice when these projects are incorporated into AFAs.[15]

In summary, we believe that funds may be identified in an AFA for construction purposes. However, the AFA must specify that such funds only may be obligated and expended under a specific statutory construction authority, e.g., section 102 of ISDA, section 103 of ISDA, Public Law 86-121, etc.[16]

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parties. Other Federal laws related to acquisition are not applicable unless expressly provided in such law.

[14]42 U.S.C. 2004a. The appropriation act specifies that any funds transferred from the Department of Housing and Urban Development (HUD) to IHS are used under the authority of ISFA and ISDA.

[15]Further, as discussed below, IHS may not contract for inherent Federal functions.

[16]Similarly, we note that funds appropriated and allocated under the Indian Health Care Improvement Act for construction must be obligated and expended under that authority.

III. ALLOCATION OF FUNDS

A. STATUTORY REQUIREMENTS

This opinion naturally raises questions with respect to allocation of construction funds. In addressing these questions, it is important to consider the interrelationship among the following three sections of ISDA. First, section 303(a)(6) states that the Secretary shall provide an amount equal to that which the tribe would have been eligible to receive under a Title I contract. Second, section 106(a) states that the amount of funds provided to a tribe with a self determination contract shall not be less than the IHS otherwise would have provided for the operation of the program. Further, the amount of funds may include a tribe's share of certain headquarters and area office functions, commonly referred to as "tribal shares." Third, section 306 states that the Secretary may not interprat ISDA to reduce funds that any other tribe is eligible to receive under section 102. Thus, the allocation of construction funds must be consistent with these statutory provisions.

Based on these statutory requirements, we believe that the amount of the contract is what the Secretary otherwise would have provided for the construction of the facility.[9] It is our understanding that the agency provides Congress with estimated costs for the construction of specified facilities. Next, the appropriation committee identifies a specified amount in the lump sum appropriation for a particular facility. Subsequently, the agency determines final cost estimates for the facility and awards a contract for direct Federal construction. We note that the amount of the contract is based on the final cost estimate. Any difference in this amount and the amount identified in the legislative history remains with the Federal agency.

B. INHERENTLY FEDERAL FUNCTIONS

As noted in our August 23, 1993 opinion, IHS has functions which are inherently Federal, e.g., contracting officer. In other words, functions which must be carried out by a Federal employee. IHS may not

[9]Section 106(a)(1) of ISDA.

enter agreements which allocate funds that are associated with inherently Federal functions. Of course, it is a matter of agency discretion to determine the amount of funds necessary to carry out these Federal functions.

C. CONGRESSIONAL INTENT

IHS receives a lump sum appropriation for facilities construction. In the absence of specific statutory direction, the allocation of funds from a lump sum appropriation is a matter of agency discretion.[20] We note that the appropriation act usually does not require that IHS spend appropriation funds in the IHS facilities appropriation on particular projects.

However, the appropriation committee reports do specify that funding is earmarked for particular health care facility construction projects. While an agency is not bound by this legislative history, "an agency's decision to ignore congressional expectations may expose it to grave political consequences."[21] The IHS facilities appropriation also includes funding for sanitation facilities which is distributed based on the agency's priority system.[22] We find nothing in Title III that requires the agency to change its method of allocating funds appropriated for health care facility construction or for sanitation construction.

Further, as explained above, section 106(a), which governs Title III allocations under section 303(a)(6), ties funds available for compacting to what the IHS "otherwise would have provided for operation of the program." In other words, if IHS would have allocated funds for the construction of a specified facility which would serve a particular tribe, then another tribe, which would not benefit, is not entitled to tribal shares with respect to that project.

For example, a tribe might argue that under an allocation methodology for tribal shares, it is entitled to its share of the entire appropriation for

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[20] Lincoln v. Vigil, 113 S.Ct 2024, 2031 (1993).

[21] Id. at 2032.

[22] See section 302 of the Indian Health Care Improvement Act.

facilities, including funds for particular projects. If the tribe takes "its share", there may not be sufficient remaining funds to construct the health care facilities for which Congress included funds in the appropriation. Similarly, a tribe might argue that it is entitled to its share of sanitation facilities construction funds. If IHS provides these tribes with their "share" of such funds, it may violate Congressional intent that these funds be allocated on a priority basis. If the agency provides tribal shares in such cases, it may face severe criticism from Congress.

Therefore, in calculating tribal shares, the agency should consider the amount it would otherwise have provided for the program under section 106(a) together with any applicable legislative history.

IV. PAYMENT OF FUNDS

As discussed above, if a tribe desires it may choose to identify funds in its AFA for construction and obligate and expend such funds under a Title I construction contract, a Title I grant, or, in the case of sanitation facilities, through an agreement authorized under the ISFA. In such a case, payment of funds would be governed by section 105(b) of ISDA which states:

> Payments of any grants or under any contracts pursuant to sections 102 and 103 of this Act may be made in advance or by way of reimbursement and in such installments and on such conditions as the appropriate Secretary deems necessary to carry out the purposes of this title. The transfer of funds shall be scheduled consistent with program requirements and applicable Treasury regulations, so as to minimize the time elapsing between the transfer of such funds from the United States Treasury and the disbursements thereof by the tribal organization, whether such disbursement occurs prior to or subsequent to such transfer of funds.

We understand that the IHS currently is considering various legal instruments for constructing facilities, e.g., grant, a cost-reimbursement contract, a fixed-price contract, etc. Notwithstanding the type of instrument used, the transfer of funds must minimize the time elapsing between the transfer of such funds from the Treasury and the disbursement by the tribal organization.

In conclusion, the Comptroller General has determined that an agency must have express statutory authority to use Federal funds to improve non-governmental property. While funds may be identified in an AFA for construction of health care facilities or for sanitation construction, such funds must be used under an appropriate instrument pursuant to statutory authority, e.g., Title I contract, Title I grant, agreement authorized by ISFA, etc.[2] In determining funds available for tribal shares, the agency should consider the applicable sections of ISDA noted above, inherently Federal functions which the agency must carry out, and congressional intent with respect to funding particular projects. Finally, the agency has fairly broad discretion with respect to the payment of funds under a Title I contract or grant and should consider what is most advantageous in carrying out the purposes of ISDA.

I hope this information is helpful to you. If you have further questions, please feel to give me a call at 301-443-0406.

Barbara Hudson

Barbara Hudson

cc: Richard McCloskey, Director
Division of Legislation and Regulations

Quinault Indian Nation

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TESTIMONY OF
PEARL CAPOEMAN-BALLER, PRESIDENT
QUINAULT INDIAN NATION
Submitted To The
SENATE COMMITTEE ON INDIAN AFFAIRS
On The
OVERSIGHT HEARING ON THE IMPLEMENTATION
OF THE INDIAN HEALTH SERVICE
SELF-GOVERNANCE DEMONSTRATION PROJECT
MAY 2, 1995

Members of the Senate Committee on Indian Affairs, as President of one of the first Tribes to participate in the IHS Self-Governance Demonstration Project, I would like to provide this written statement on the implementation of the Project.

During our first year of compacting with the IHS, the Quinault Nation has been frustrated by the same road blocks that were encountered during the planning and subsequent years of compacting with the Department of Interior. A few years ago Self-Governance Tribes sighed with relief as we began the process of assuming control of the Federal funding that has crippled our existence for too many years - the biggest monster lurking in Indian Country - the BIA. The only other monster of comparable destructive capability is the IHS. Much to our chagrin, we are facing the very same difficulties with intransigence in the IHS as we did with the BIA seven years ago. The problem is that Tribes thought attaining Self-Governance would be less complicated and burdensome as we continued our quest towards regaining the operations of our Tribal governments. Yet, as Quinault is about to enter into it's second round of Compact negotiations with the IHS, believe me, easier, it isn't!

SPECIFIC ISSUES:

(1) THE OFFICE OF SELF-GOVERNANCE AS PART OF THE OFFICE OF THE HHS SECRETARY'S OFFICE

It is imperative that the Office of Self-Governance (OSG) is elevated to the level of the Secretary of the Department of Health and Human Services (HHS), rather than under the Director of the Indian Health Service. Tribes have been subjected to delays in the distribution of funds due to be transferred under the terms of our annual funding

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agreements, mainly attributable to the under staffing of the OSG. This delay has hindered timely decision making on the part of the IHS on crucial policies and methodologies, such as Central Office joint allocation methodology, identification of residual resources, and user population definitions.

Tribes need the assurance that the HHS proposed IHS Self-Governance Policy Council will not be established until the IHS and Tribes can mutually agree on its purpose and role in the implementation of Self-Governance.

(2) CONTRACT SUPPORT COSTS

According to the contract support funding provisions of the Indian Self-Determination Act, Tribes should receive full funding of Tribal administrative costs. However, the IHS policy for administering contract support funds, does not address contract support needs associated with Tribal share resources that are made available to Tribes under Self-Governance and the recent amendment to Title I of the Act of P.L. 103-413. Tribal leaders and representatives have met with the IHS Director and staff on numerous occasions over the past ten months to develop options and recommendations regarding policies which govern contract support costs relative to Self-Governance, and to address the FY 1995 projected shortfall in the Indian Self-Determination (ISD) fund. The IHS proposed percentage does not reflect the recommendations of Tribal participants and will result in inaccurate reporting of actual contract support needs. We request full Tribal participation in the development of a process in which Tribes will receive 100% contract support based on actual program and administrative costs, with any deficiency in funding reported to Congress and not based on an impetuous decision by the IHS.

Specifically, it is unclear whether the recommendations included in the proposed policy apply to just the ISD funds, or to the larger "contract support cost" pool. Furthermore, the proposed interim policy would reduce the indirect costs shortfall reported to Congress, resulting in eventual reductions of appropriations of health care funding to Indian people.

We respectfully request your assistance in directing the IHS to fully fund documented Tribal contract support costs needs and to develop contract support costs policies and recommendations consistent with current Indian Self-Determination legislation.

(3) SHORTFALL AND FULL FUNDING OF TRIBAL SHARES

Initially the Federal policy in dealing with the Indian Self-Determination Act envisioned a clear cut transfer of resources from the Federal government to the Tribes as Tribes chose to assume local Tribal programs. Under Self-Governance, shortfall funds have been provided to support transitional costs associated with the transfer of resources to those Tribes with a Compact and to avoid any negative financial impact to other Tribes. The IHS needs to develop a means by which to monitor, by program or other activities, the increase in the level of compacting and contracting by Tribes and related reductions in staff and other resource requirements. Such monitoring will alleviate the need for shortfall funding to meet transitional needs. Unless Federal reductions accurately parallel with increases in compacting, stable base funding, with recurring funds cannot be achieved.

(4) CONSTRUCTION CONTRACTS

The Office of the General Counsel issued an opinion on Tribes ability to contract under P.L. 93-638 to perform construction contract management, however, they are not allowed to do so under Title III. If Tribes are allowed to enter into such contracts with the BIA, why is it not possible to perform the same services with the IHS?

The Quinault Nation requests the Committee to include a provision in the permanent IHS Self-Governance legislation that authorizes Self-Governance Tribes to compact construction project management.

(5) EDUCATION AND COMMUNICATION PROJECT

The expansion of the Self-Governance Project, with up to thirty Tribes a year receiving planning grants for the next ten years, increases the need for additional funding for communication and education efforts. Increased funding was requested by Tribes in testimony they presented before the House, and submitted to the Senate, for the FY 1996 Appropriations in the amount of $200,000 for an IHS-related Lummi Self-Governance Education/Communication initiative. This will make it equal to the BIA-related project.

We ask this Committee to provide assistance to Tribes in securing this much needed increase to maintain the current dissemination of information among Tribes, and also to provide an information resource to new and future Tribes, whether they are seeking Self-Governance or not.

(6) IHS FALSELY ATTRIBUTING ADVERSE IMPACT TO SELF-GOVERNANCE

Earlier this year, I attended a briefing of the National Indian Health Board in Washington, DC, on the fiscal year 1997 budget as it is being developed by the Indian Health Service. I was dismayed to hear officials of the Federal government represent to the Tribes in attendance that the fiscal constraints and shortfalls of the proposed budgets are directly attributable to the Self-Governance initiative.

I am particularly concerned that these statements may reflect the official position of the Indian Health Service and the Department of Health and Human Services. One consequence already evident is that Tribes that do not have Self-Governance compacts are being led to believe that the Self-Governance initiative is having an adverse impact on the resources available for their programs. In a letter to Dr. Michael Trujillo, Director of the Indian Health Service, I inquired whether this was the official position of the Indian Health Service and, therefore, the statements of the Department of Health and Human Services. Further, I asked "when and in what form these positions were approved by the Department's Office of the General Counsel, particularly as non-compacting Tribes may challenge what they have been told is an adverse impact on their programs".

The malicious intent of such untruths by an upper level Federal employee, can only have one end result - that Tribes who actually believe this rhetoric will become adverse to the intent of Self- Governance. Although it is impossible to control slander and maintain damage control with a Project as successful as Self-Governance, the successes of the Project must be shared with the public.

Thank you Mr. Chairman, for the opportunity this oversight hearing has afforded me to let the public know that Self-Governance is working, not just for the Quinault Indian Nation, but for many, many Native American and Alaskan Native Peoples.

Quinault Indian Nation

POST OFFICE BOX 189 □ TAHOLAH, WASHINGTON 98587 □ TELEPHONE (206) 276-8211

March 29, 1995

The Honorable John McCain, Chairman
Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

RE: Indian Health Service - FY 1995 Draft Policy Concerning Contract Support Costs

Dear Mr. Chairman:

We are writing to convey to you our strong objections to the recently proposed Indian Health Services' FY 1995 Contract Support Costs Draft Policy and to request your intervention prior to any formal IHS adoption of this proposed policy. We have reviewed the proposed policy and feel that, if enacted, this policy will have a devastating effect on Tribal government operations. There are many issues and concerns raised in the proposed policy which are not adequately addressed, and more importantly, are clearly contrary to the spirit and intent of the recently enacted PL 103-413 "Tribal Self-Governance Act of 1994". Indeed, the proposed policy is directly contrary to section 303(a)(6), which mandates that Title III Compacts include 106(a)(2) funds - contract support costs - within the Annual Funding Agreement, just as is the case with Title I Contracts.

Tribal leaders and representatives have met with the IHS Director and staff on numerous occasions over the past ten months to develop options and recommendations regarding policies which govern contract support costs relative to Self-Governance and to address the FY 1995 projected shortfall in the Indian Self-Determination (ISD) fund. The summaries and proposed draft policies presented by the IHS staff do not reflect the recommendations provided by the Tribal participants.

Specifically, it is unclear whether the recommendations included in the proposed policy apply to just the ISD fund or to the larger "contract support cost" pool. Furthermore, the proposed interim policy would reduce the indirect costs shortfall reported to Congress, resulting in eventual reductions of appropriations of funding for health care to Indian people.

As you are well aware, contract support funds or indirect costs are a universally recognized cost of doing business. Tribal governments have their indirect cost rates established through independent review and analysis by the Office of the Inspector General. Every Administration since the Nixon Self-Determination Policy and every Congress since that period have encouraged, by expressed policy, Tribal governments to assume management of both BIA and IHS programs. The logical consequence of this policy implementation is ever-increasing Tribal 638 Contracts and Self-Governance Compacts and the relative evolution in sophistication of Tribal governments in managing these resources.

The lack of financial resources to cover associated Tribal contract support fund expenditures is not the fault of the Tribes; but rather the direct result of the short-sighted budget projections and financial planning of the Indian Affairs Agencies. These unexpected, roller-coaster contract support costs policies developed by the IHS not only create instability and chaos at the Tribal government level, but are in violation of good faith negotiated agreements. The progress and success we have demonstrated and achieved through Self-Governance are being threatened by this lack of funding. By actual or designed error, the IHS has placed the burden of covering Tribal indirect costs on the Congressional Appropriations Committees.

Attached is a copy of a recent letter sent to Dr. Trujillo on the proposed draft contract support cost policy. We respectfully request your assistance in directing the IHS to fully fund documented Tribal contract support costs needs and to develop contract support costs policies and recommendations consistent with current Indian Self-Determination legislation. We thank you and your staff for your continued support as we move forward under Self-Governance.

Sincerely,

Pearl Capoeman-Baller, President
Quinault Indian Nation

On behalf of those Tribal delegates represented at the March 29, 1995, Tribal Caucus in Reno, NV (see attached list).

Attachments: Letter to Dr. Trujillo from Dale Risling, Chairman, Hoopa Valley Tribe dated March 22, 1995
IHS Proposed Draft Concerning FY 1995 Policy on Contract Support Costs dated March 1995

LJMCSFIH 492(95)

Tribal Attendance List
National Pre-Negotiation Meeting
March 29, 1995

1. Absentee Shawnee Tribe
2. Alaska Native Health Board
3. Aleutian Pribolof Association
4. Blackfeet Tribe
5. Bristol Bay Area Health
6. Cherokee Nation
7. Chickaloon Native Village
8. Chickasaw Nation
9. Chippewa Cree Tribe
10. Choctaw Nation of Oklahoma
11. Chugachmiut
12. Coeur D' Alene Tribe
13. Colville Tribe
14. Confederated Tribes of Siletz
15. Confederated Salish & Kootenai
16. Confederated Tribes of Grand Copper
17. Copper River Native Corporation
18. CS Elk Tribe
19. Duckwater Shoshone Tribe
20. Eastern Band of Cherokee
21. Ely Shoshone Tribe
22. F & L Chippewa
23. Fallon Paiute Shoshone Tribes
24. Fond du Lac Reservation
25. Fort Belknap Community Council
26. Grand Ronde
27. Great Lakes
28. Ho Chunk Nation
29. Hoopa Valley Tribe
30. Jamestown S'Klallam Tribe
31. Jicarilla Apache
32. KANA
33. Kaw Nation of Oklahoma
34. Kodiak Area Native Association
35. Kootenai Tribe of Idaho
36. Lower Elwha Klallam Tribe
37. Lummi Nation
38. Makah Tribe
39. Maniilaq Association
40. Mississippi Band of Choctaw Indians
41. Metlakatla
42. Miccosukee
43. Mille Lacs Band of Ojibwe
44. Muscogee Creek Nation
45. Navajo Nation
46. NC Tribal Health
47. Nialehik Traditional Council
48. Nisqually Indian Tribe
49. Northern Cheyenne
50. Norton Sound Health Corporation
51. Oneida Nation - Wisconsin
52. Ottawa and Chippewa Indians
53. Pascua Yaqui Tribe
54. Penobscot
55. Poarch Creek Indians
56. Ponca of Oklahoma
57. Port Gamble S'Klallam Tribe
58. Quileute Tribe
59. Quinault Indian Nation
60. Redlake
61. Reno-Sparks Indian Colony
62. Sac & Fox Nation
63. Saginaw Chippewa Tribe
64. Salt River Indian Community
65. San Carlos Apache Tribe
66. Santo Domingo
67. Seminole Tribe of Florida
68. Shoshone-Paiute Tribes
69. Skokomish Tribe
70. Southern Ute Tribe
71. South Fork Reservation
72. South Central Foundation
73. Squaxin Island Tribe
74. St. Croix Chippewa
75. Stockbridge Munsee
76. Tanana Chiefs Conference, Inc.
77. TE Mouk Western Shoshone
78. Tulalip Tribe
79. Ute Tribe
80. Walker River Paiute Tribe
81. Washoe Tribe of NV/CA
82. White Mountain Apache Tribe
83. Wyandotte Tribe of Oklahoma
84. Yak-Tat Kwaan, Inc.
85. Yakama Nation
86. Yakutat Tlingit Tribe
87. Yavapai Apache Tribe
88. Yukon Kuskokwim Health Corporation

March 22, 1995

Dr. Michael Trujillo, Director
Indian Health Services
5600 Fishers Lane
Rockville, MD 20857

RE: Fiscal Year 1995 Contract Support Concerns

Dear Dr. Trujillo:

Thank you for meeting with the Self-Governance Tribes in attendance at the Regional Forum on Indian Health Care in Clackamas, Oregon. We met with you to follow-up on concerns identified by the Tribal Leaders and delegates representing 253 Tribes at the February 16, 1995, Tribal Caucus in Washington D C. This letter is intended to even more clearly convey our concerns about the decision making process regarding Contract Support Costs (CSC) on Tribal shares and the CSC shortfall. We believe that very specific preparation must be done by your staff prior to the National Self-Governance Pre-Negotiation Meeting to be held in Reno, NV next week.

Tribal representatives have met with Indian Health Service (IHS) staff on more than one occasion to develop options and Tribal recommendations regarding CSC. The summaries produced by the IHS representative present do not accurately reflect the proceedings or Tribal recommendations. Truthfully, they are not even recognizable to the Tribal participants. Accordingly, we are concerned about the quality of information and analysis you are receiving regarding CSC issues.

To assist in your review of this issue, we are enclosing a packet of the correspondence regarding contract support. Enclosed are:

March, 1995	IHS Proposed Draft Fiscal Year 1995 Policy Concerning Contract Support Costs,
February 17, 1995	Letter to Dr. Trujillo from Dale Riesling on behalf of Tribal Leaders and Delegates Representing 253 Tribes;
January 27, 1995	Letter to Associate Director, Office of Tribal Activities, from Lee Olson, Vice-President of Administrative Services for the Yukon-Kuskokwim Health Corporation and Work Group Tribal Participant, objecting to the December 13, 1994, Report of the Work Group Recommendations;
December 13, 1994	Contract Support Costs Work Group Recommendations (prepared by an IHS Representative);
November 1994	Draft Recommendations to Indian Self-Determination Memorandum No. 92-2, IHS Contract Support Cost Policy, prepared by group of Northwest Tribes,
October 26, 1994	Letter from Dr. Trujillo to Chairman, Lummi Indian Business Council, regarding concerns about policy recommended by OTA;

August 31, 1994	Letter to Dr. Trujillo from Tribal Leaders of Quinault, Lummi, Jamestown S'Klallam, Sac & Fox, and Hoopa Tribes regarding Interim FY 1995 Funding Policy for Contract Support Cost;
August 1994	OTA Recommendations Presented to CAAD;
July 24, 1994	Presentation prepared by Deputy Associate Director, OTA, for CAAD "to communicate some of the WG recommendations" of June 9 & 10 Portland Meeting;
June 12, 1994	Memo to All IHS Self-Governance Tribes from William Parkhurst identifying options regarding contract support.

You will note that deliberations on this matter have been ongoing since June 1994 -- ten months! The Tribal communications articulate many options, none of which are reflected in any of the products of OTA, nor, do the materials from OTA reflect adequate information or analysis on which to base decisions Although we are six months into the fiscal year, there is no definitive list of CSC needs

The delays in resolving issues regarding CSC are detrimental to all Tribes and must be resolved without further delay To this end, we respectfully request that you direct your staff to prepare a written analysis of each Tribal option that has been proposed and the latest OTA draft proposal. The analyses should be supported with detailed financial analysis based on an up-to-date information regarding CSC requests and projections. **The analysis must reflect the full Tribal demand for CSC assuming the principals of ISDM 92-2 are applied to all Tribal compact funds including Contract Support on Area and Headquarters Tribal shares**, as well as the amount calculated under each of the options and the IHS draft proposal This material should be available at the beginning of the National Meeting in Reno so that it can be reviewed by Tribal Leadership prior to any discussion of this subject.

We further request that you make it a priority to reach a decision on this matter. The government-to-government relationships that underpin the Self-Governance Compacts are undermined when we are unable to bring negotiations to a close from one year to the next. It is alarming that an FY95 issue of this magnitude is still unresolved as we begin prenegotiations for FY 96 Annual Funding Agreements We look forward to your personal and immediate attention to this matter.

Sincerely,

Dale Risling, Tribal Chairman
Hoopa Valley Tribe

DRAFT

FY 95 POLICY CONCERNING CONTRACT SUPPORT COSTS

Ongoing Need for Contract Support Costs

Recurring contract support costs will be distributed to tribes (self-determination and self-governance) operating programs under P.L. 93-638, as amended, according to ISDM 92-2, IHS Contract Support Cost Policy. This amount is $145 million in FY 1995.

Any shortfall in contract support costs is reported to the Congress three times yearly for consideration in the budget appropriations process.

Contract Support Cost Funding for New Tribal Assumptions

Contract support cost funding for tribes (either self-determination or self-governance) assuming IHS programs is provided through the Indian Self-Determination Fund (ISDF).

The ISDF is a special fund requested by the IHS and approved by the Congress to address the contract support costs needs associated with new program assumptions by tribes. The ISDF has grown from $2.5 million (FY 1988-1992), to $5.0 million (FY 1993) to $7.5 million (FY 1994-1995).

In most years, the amount of requests from tribes proposing to assume IHS programs has exceeded the amount of funds available from the ISDF.

Contract Support Cost Funding for Self-Governance "Tribal Shares"

In FY 95, the policy of the IHS is not to add contract support costs to tribal shares used to provide services to tribal members. However, the amount negotiated for tribal shares of Area Office and Headquarters operating funds will be available for use by the tribe as program funds and contract support cost funds.

The IHS will make an exception to this policy for those compacts and/or annual funding agreements negotiated for FY 1995 that may commit the IHS to adding contract support costs in situations where tribal shares applied to increasing services generate an additional need for contract support costs. The IHS is interested in renegotiating any commitment the Agency may have made in these situations. In the absence of any renegotiations, the IHS will honor any commitments made by the Agency in compacts/and or annual funding agreements.

Quinault Indian Nation
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May 8, 1995

The Honorable John McCain
Chairman of the Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510
ATTN: Barbara Robles

Dear Chairman McCain:

I am writing to express my concern about two issues involving the Indian Health Service's actions as a Federal agency mandated by Congress to assist Tribes in our efforts to accomplish Self-Governance. The first involves public statements made by IHS officials and the second involves the draft "policy" on contract support costs.

On March 14th, as an alternate to the National Indian Health Board, representing the Portland Area Tribes, I attended a briefing of the National Indian Health Board in Washington, DC, on the fiscal year 1997 budget as it is being developed by the Indian Health Service. I was dismayed to hear officials of the Federal government represent to the Tribes in attendance that the fiscal constraints and shortfalls of the proposed budgets are directly attributable to the Self-Governance initiative.

As President of one of the first Tribes to participate in the Self-Governance initiative, I am particularly concerned that these statements may reflect the official position of the Indian Health Service and the Department of Health and Human Services. One consequence already evident is that Tribes that do not have Self-Governance compacts are being led to believe that the Self-Governance initiative is having an adverse impact on the resources available for their programs.

In correspondence to Dr. Michael Trujillo, Director of the Indian Health Service, on March 17, 1995, I inquired whether these are the official positions of the Indian Health Service and, therefore, the statements of the Department of Health and Human Services. Further, I asked "when and in what form these positions were approved by the Department's Office of the General Counsel, particularly as non-compacting Tribes may challenge what they have been told is an adverse impact on their programs".

A separate, but related issue involves the revised draft "policy" statement being considered by the IHS at this time on contract support for Self-Governance compacts. It is my firm belief that the IHS lacks the authority to issue such a "policy" because of the clear direction of Congress found in the statutes and legislative history leading to the Self-Governance initiative. In addition, should the Service interpret its mandate to be sufficiently broad that it could issue such a directive, it is my position that the procedure contemplated may well violate the Administrative Procedures Act.

More importantly for present purposes, dissemination of draft "policy" statements such as this only compounds the atmosphere of suspicion that the BIA and now the IHS has generated about Self-Governance. The delay tactics of creating yet another task force or workgroup only creates obstacles to Self-Governance implementation. Roadblocks and suspicion will not help our constituents receive the health care they need.

Your assistance in minimizing this type of environment will go a long way towards allowing all of us to perform our real task of helping Indian people lead healthy lives. I'm requesting that this letter be placed on the record of the May 2, 1995, Oversight Hearing on IHS Implementation of the Self-Governance Demonstration Project.

Sincerely,

Pearl Capoeman-Baller

Pearl Capoeman-Baller
President

PCB/sbt

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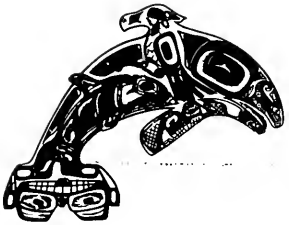


SQUAXIN ISLAND TRIBE

Testimony of Squaxin Island Tribe
Senate Committee on Indian Affairs
IHS Self Governance Implementation Oversight Hearing
May 2, 1995

The Squaxin Island Tribe appreciates your invitation to testify before the Senate Committee on Indian Affairs regarding the Indian Health Service Self Governance Demonstration Project. We are very sorry that we were unable to attend, but *greatly appreciate the invitation and the efforts you personally have contributed to Self Governance.* Without your efforts, it is highly likely that the enormous bureaucracies of the Federal government would have gobbled up the efforts of Tribes to govern themselves.

Though we were unable to attend the Hearing, we would appreciate your entering this testimony into the Congressional Record. Indian Health Service Self Governance has been very beneficial to the Squaxin Island Tribe and we would like to give you and your Committee some concrete examples.

Besides the most obvious effect of additional dollars to the Tribe, Self Governance has a more pervasive effect by moving the control of Federal dollars to the local level. This movement of control to the local level has two driving forces. They are: 1) **the ability to better leverage dollars**, and 2) **more incentives to manage efficiently and effectively.**

1. The Ability to Better Leverage Dollars

Before Self Governance the Squaxin Island Tribe operated a health clinic out of an 800 square foot portion of the Natural Resources building which is an old school abandoned by the local school district. We were so cramped for space, that patients who had to give urine samples were required to exit the side door of the clinic go through the Natural Resources department to the restrooms and then return with their sample for all to see.

In addition, our exam rooms also served as storage rooms while everyone else shared desks and space. Needless to say, this is a very unacceptable way to provide medical services. However, the Tribe could never get high enough on the IHS priority list to build a new clinic. The IHS was using their budget for hospitals and very large facilities. Meanwhile, most of the small Tribes were operating in third-world facilities.

SQUAXIN ISLAND TRIBE / S.E. 70 Squaxin Lane / Shelton, WA 98584 / Phone (206) 426-9781
Tribal Council (206) 426-9783 Natural Resources (206) 426-9783 Health Clinic (206) 427-9006

In the meantime, the Tribe was pursuing a long-term, low-interest loan with the FmHA. We couldn't borrow from local banks because the Tribe had no acceptable or legal forms of collateral. The FmHA loan looked good, but again, they didn't require collateral but did require a dedicated source of funds for the debt re-payment. We examined our Self Governance funds and discovered it was legal to dedicate those funds to the loan.

Consequently, after a year of design and loan preparation, the Tribe will begin construction of a new 8,500 square foot facility next month. The facility will house the programs of: Primary Care, Dental Care, Mental Health, Community Health, Contract Health and Alcohol/Substance Abuse. The new Center will serve as the focal point for the promotion of the mental and physical well-being of Community members.

We could have never built this new facility without Self Governance. Our yearly debt payments of around $35,000 (of Self Governance funds) have been leveraged into almost a million dollar facility. It may have taken years, if ever, for IHS to move us up a priority list so that they could have 100% of the funds prior to construction. *Instead we leveraged a smaller amount of funds to receive a much needed building today.*

2. More Incentives to Manage Efficiently and Effectively

Because of Self Governance, there is more local Community involvement. The Tribal budgets are completely open with a great deal of input before Council approval. Before Self Governance, we had a contract which told us exactly what we could and could not do. Consequently, there was little Tribal Community interest because there was no Community control. Now, with Self Governance we have the control and consequently there is much interest in the Tribal Community.

Consequently, *there is now more incentive to manage programs more efficiently and effectively.* A perfect example is our Self Governance of the Contract Health Program. During our first year of Self Governance operation we will save over $60,000 out of a $425,000 Contract Health budget. We did not save this money by cutting services. Instead we saved it by managing the program more efficiently than the Indian Health Service. For example, we have cut the over-use of emergency room visits by patients. Instead we now use less expensive Urgent Care Centers. We have saved money by entering Preferred Provider Networks and by negotiating discounts with local providers and hospitals. In addition, we have entered into networks which will save us over 20% on prescription drug costs.

We haven't stopped there. Because of Self Governance, we can now operate the computer system of our choice. Before, IHS told us what to use and gave us little, if any, flexibility to operate better billing and managed care systems. We purchased a new networked computer system which we estimate we improve third-party insurance collections by over 100%.

Why are we improving our health delivery system? What is our incentive? The incentive is to find additional funds which can be used to provide better services Our incentive is to provide the best service possible IHS has no incentive to save on Contract Health. If they run out of money, they just go back to IHS headquarters and ask for more In addition, they have no incentive save on provider costs or to save on prescription drugs or to improve their computer systems. If we save money, we can use it to hire additional health providers or allow elders to purchase hearing aids and eyeglasses when they need them in a timely fashion, instead of at the end of the year like IHS used to do

We see our patients everyday. *We know who will benefit if we operate more efficiently.* Our patients are only User Population numbers to the IHS worker

We could go on and on, but the bottom line is that local Communities and Tribes, will always strive to provide better services to their Community than faceless bureaucrats Our incentive is to provide better service. The bureaucrats incentive is to regulate and heap mounds of ridiculous red-tape and paperwork upon us Do you know that before Self Governance we were required to submit a multi-page form to purchase a Hewlett-Packard LaserJet printer. Even if it was in our budget, we still had to submit the paperwork prior to purchase It could take 3-5 weeks for the approval All of this for a printer which is an industry standard with millions sold When asked, the IHS personnel told us, "yes they feel this requirement is ridiculous, but they have to follow regulations " Well, with Self Governance, we don't have to follow these ridiculous rules If the Council approves the budget, then you can purchase your printer as you need it to improve your department's operations. Again, local incentive, local benefit.

Senator McCain, the changes in just our first year of IHS Self Governance have been phenomenal We will have a new Health Center by the end of the year We are saving money by more efficiently operating our programs and we are adding new services like local dental programs, health promotion classes, Community wellness programs, a van for home health visits and more

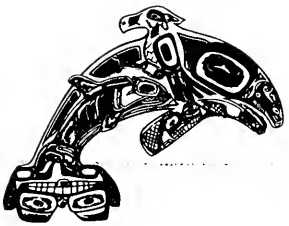
One additional comment on the transfer of Federal programs to the local level. The examples of BIA and IHS Self Governance show that local entities are better at developing their priorities and managing programs as they see fit and as the local Community sees fit through everyday involvement and input. This does not mean the Federal government does not have a trust responsibility for American Indian Tribes They do *What it means is that we are fully capable of governing, managing and helping to improve ourselves.* This can also be true of the many Federal social programs which are currently being analyzed by Congress to transfer to States and Tribes Everyone understands why the Federal government became involved in these programs years ago. At the time, Federal control was needed However, *to fully improve the lives of those in need, we must transfer the funds, control and power closer to those who will be served by these services.* Only then will we begin to see improvements.

It should be noted, that while we appreciate the need to reduce the deficit, it is very difficult for the Federal government to ask Tribes (or local governments) to take on the Federal responsibility with less funds than the Federal agencies themselves have used

Without Self Governance we would not have the control, leverage or incentive to make our health programs better. Self Governance has allowed us, the Tribe (at the local level) to do what might have taken the Federal IHS program years to accomplish. **Our people are the ones who will benefit.**

Thank you Senator McCain for your efforts in Self Governance *You and others on the Committee have done a great service to improve the lives of American Indians.*

TSCIAIHS 311



SQUAXIN ISLAND TRIBE

July 11, 1995

The Honorable John McCain, Chairman
Committee on Indian Affairs
United States Senate
Washington, DC 20510-6450

Dear Senator McCain,

In the Squaxin Island Tribe's written testimony on *IHS Self Governance Implementation Oversight Hearing*, we described with excitement the many things we are able to do because of Self Governance One of the most exciting, is the ability to leverage Self Governance funds to construct a new 5,000 plus square foot health facility

However, the enclosed letter to Dr Trujillo describes the frustration we are having over the distribution of new funds Congress has appropriated for medical equipment in new health facilities Squaxin Island is eligible for these funds but because of the secretive and closed manner in which the distribution formula was developed, we fear we won't receive any of this funding. The IHS failed to listen to our comments and did not seek comment or feedback on the proposed formula. Instead a formula was approved which favors larger Tribes and larger facilities in remote or rural areas We don't feel this formula was developed this way intentionally. Rather, it shows why Tribes want to go into Self Governance, namely because we can't trust the IHS to perform their duties fairly, competently or in a partnership with the Tribes.

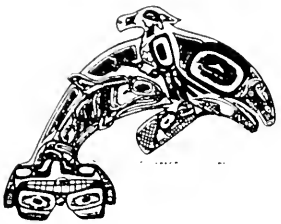
We are very frustrated with the process of distribution of these funds; particularly after the very frustrating manner in which the Self Governance negotiations were conducted this year. The IHS mandated changes at the last moment with little or no discussion or agreement from the Tribes.

Senator McCain if there is anything you can do to assure that IHS test the fairness of the distribution of the funds associated with the new medical equipment, we would greatly appreciate this. Please feel free to contact myself or our Health Director, Brent Simcosky for any questions or concerns. Thank you for your support of the American Indian Tribes

Sincerely,

David Lopeman
Chairman

SQUAXIN ISLAND TRIBE / S.E. 70 Squaxin Lane / Shelton, WA 98584 / Phone (206) 426-9781
Tribal Council (206) 426-9783 Natural Resources (206) 426-9783 Health Clinic (206) 427-9006



SQUAXIN ISLAND TRIBE

July 1, 1995

Dr Michael Trujillo, Director
Indian Health Service
U S Department of Health and Human Services
5600 Fishers Lane
Parklawn Building
Rockville, MD 20857

Dear Dr. Trujillo,

Two months ago the Squaxin Island Tribe began construction of the new Sally Selvidge Health Center, named in honor of Tribal member Sally Selvidge, who managed the Clinic and who recently died of cancer This new facility will house the programs of Primary Care, Dental, Mental Health, CHS and Community Health. The Squaxin Island "Sally Selvidge" Health Center will be used to consolidate current health programs into one facility and to greatly expand new services currently not available due to lack of facilities Upon completion, the Center will serve as the focal point for the promotion of the mental and physical well-being of community members.

The construction is financed with a long-term, low interest loan from RECD/FmHA The financial preparation and design planning took over one year, but we're proud that we were able to find financing for a much needed facility We will receive no funds from IHS for the construction.

This brings me to the point of this letter We were very excited when Congress appropriated over three million dollars for the procurement of medical equipment for Tribal facilities constructed without the use of IHS construction funds However, we are **very unhappy and disappointed with the manner in which IHS has taken to distribute these funds.** A formula was developed which clearly favors large facilities in remote or rural areas The formula was not put out for Tribal comment nor was it tested for fairness Below is a review of the problems with the process of the formula development and problems with the formula itself

SQUAXIN ISLAND TRIBE / S.E. 70 Squaxin Lane / Shelton, WA 98584 / Phone (206) 426-9781
Tribal Council (206) 426-9783 Natural Resources (206) 426-9783 Health Clinic (206) 427-9006

Problems with Process

Why does it take IHS so long to distribute funds? Last summer our Health Director became aware that Congress was interested in appropriating these funds. He learned that IHS was also aware of this. Once the budget was approved, our Health Director, Brent Simcosky, contacted IHS Director Jim Waskiewicz and was told that they needed to develop some sort of formula. Mr. Simcosky urged a quick decision as several Tribes were contemplating construction after the first of the year. *This is important because most of the equipment in a facility needs to be selected prior to construction to ensure proper installation.* Nothing happened. Mr Simcosky contacted Mr Waskiewicz at two separate Self Governance meetings again urging a quick decision. Mr. Simcosky even suggested that for the first year possibly IHS just send out notifications and see how much demand for the three million even exists. He suggested a pro rata of the funds if we were within 80% of need. Mr Waskiewicz liked this idea and said he would think about it. Still nothing happened.

Finally, after the first of the year (sometime in March), Alan Peterson was put in charge of developing a formula. Mr. Simcosky contacted Mr Peterson and again expressed a need for urgency. We were six months into the year and IHS had not put one ounce of work into distributing these vital funds!

Finally, Mr. Simcosky contacted Mr. Peterson in April and was told they (IHS) were working on a preliminary formula. Mr Simcosky asked for a copy of the formula but was never sent one. Mr. Peterson told Mr Simcosky some of the attributes of the formula over the phone. Mr. Simcosky told Mr Peterson he had some real problems with their preliminary formula. Again, Mr. Peterson said it was only preliminary and would send a copy of something more concrete. *Nothing was ever sent to the Tribe!*

Later the Tribe receives notification from the Portland Area that funds will be distributed based on a formula approved by you. Why did we have to hear about this approved formula from the Portland Area Office? ***Why wasn't the formula put out for comment?, especially after our staff raised legitimate concerns over its fairness!*** We were told there wasn't time for comments and that a group of IHS and Tribal representatives had developed the formula. Well, there would have been time if your staff had started when the funds were appropriated instead of six months later. Furthermore, this task force only had two Tribal representatives, they only met for a couple of days, and they were basically given the formula that Mr. Peterson developed and that Mr. Simcosky had expressed concerns with a month earlier.

Needless to say, this is a very sloppy, unprofessional and unfair manner in which to develop distribution formulas. As it stands, the funds still won't be distributed until August; almost one year after being appropriated.

Problems with the Formula

As I stated above, our Health Director, Mr Simcosky expressed his concerns with the preliminary formula developed by Mr Peterson Mr Simcosky felt it unfairly favored larger facilities Mr Peterson never responded to Mr Simcosky's concerns nor did he contact any other Tribes for their comments He has said the work group provided the needed Tribal inputs Below are some very legitimate concerns with each part of the formula

1. **Location Factor**

What does this have to do with need? The IHS position on this part of the formula is that the closer your facility is to another facility of equal size the less needy you are because you can share or contract for the use of the equipment The IHS Methodologies Overview states,

"The location Factor measures the potential for sharing equipment or contracting for services with nearby health care facilities. Some facilities are remote from other facilities (or cannot establish contracts for equipment sharing or service with other nearby facilities) and therefore have a greater need for on-site equipment. Some facilities are near other health care facilities, may be able to share equipment or contract services, and therefor may have less need for on-site equipment Consequently, remotely located health care facilities receive a slightly higher Location Factor The road distance, used to measure remoteness, is the distance to the nearest alternate health care facility (IHS or non-IHS).

A more thorough analysis shows why this portion of the formula is unfair We, like every other Tribal facility, must see any Native American who comes in the door If we send them to another Clinic (non-IHS, for example) because we don't have a particular piece of equipment, who pays for this? *What money are we suppose to use to contract for the use of this equipment?*

Furthermore, we are not talking about fancy specialized equipment Our equipment needs include the basics like exam tables, lights, scales, pediatric tables, etc Are we to contract out with a nearby Clinic for the use of an exam table? If we were talking about $50,000 x-ray machines, I might agree with this part of the formula. But we are not. Our equipment needs, for our new facility, are very basic and necessary for the every day operation of the Clinic. ***Since we have no funds to contract out for this equipment and because our equipment needs are essential for basic day-to-day operations, we still have the same level of need, regardless of our location.***

2. **Space Need Factor**

Formula: Required Space (User Pop x 81) - Existing Space = Space Determinate

This particular factor of the formula has a definite bias towards larger facilities. Again, a more thorough analysis shows the problems with this factor First it calculates the "real need" based on the User Population of the facility. Every Health Clinic has the basic infrastructure needs. a reception area, two-three exam rooms, lab room, nurse station, etc Again, the facility for a 1,000 patient Clinic will look almost identical to a

facility that serves 2-3,000 patients There will be a lab with the same equipment, probably only three exam rooms and only one of the specialty pieces like EKG, pediatric tables, etc. So why does this formula favor a 2,500 patient facility over a 1,000 patient facility when the equipment needs will be very similar?

Furthermore, one of the IHS task group member's told Mr. Simcosky that the group basically felt that larger facilities and Tribes were needier than smaller facilities and Tribes. This is outrageous!!! The Squaxin Island Tribe is a sovereign government which has just as much right and needs as any other sovereign government, regardless of size To still have IHS employees espousing these viewpoints is unbelievable[1]

The Space Need Factor of the formula scores in a range from 1 5 to 4 0 and *thus is the single most important factor of the entire formula.* A high scoring Tribe in this area will almost be guaranteed to have a very high total score A more workable solution may have been to calculate the percentage increase (in square feet) in a Tribe's old Clinic to their new one This would more accurately measure need due to actual increased size versus a formula which measures a "perceived" need based on a Tribe's size.[1]

We have need for more equipment because we have gone from an 800 square foot facility (Clinic) to a 5,000 plus square foot facility We need equipment for an additional 4,200 square feet of Clinic. We need the same exam tables, lights, lab equipment and patient diagnostic monitors that the larger Tribes need. ***However, this part of the formula says we're not as needy because we're smaller.***

3. Total Replacement Factor

This portion of the formula scores points based on whether the new facility is a complete replacement or an expansion to an existing facility Scoring is 1 05 for total replacement and 1.0 for an expansion This formula is probably fair but really insignificant considering the difference between 1.05 and 1 0.

Other Factors

Finally, one other factor was included in the processing of formulas which affects fairness IHS has decided to allow any Tribe which has constructed a new facility since 1991 to apply for FY 1995 monies Again, more analysis adds some insight to this decision. *Wouldn't a facility constructed in 1991 be equipped by now?* Because of the biases towards remoteness and largeness, a remote, large facility constructed in 1991 could receive 17% of their construction costs for new equipment. Since they are likely to already have the basic equipment (which FY 1995 Tribal facilities need) they could use

[1]In addition, the IHS is calculating nonmedical related IHS programs under the existing space. For example, Squaxin Island has an alcohol program which is twice as large as nearby Tribes (we serve many non-Squaxin Island members). They are located in a modular building which is separate from the demolished Clinic which is being replaced. Yet, they are counting the Alcohol Program office space as part of the existing space, even though they require no medical equipment and they will not be in the new facility but will remain in their existing space.

their funds to purchase elective or specialty equipment. ***In other words, Tribes with new facilities in 1995 may not be able to equip their facility with the basics while a higher scoring (previously constructed) facility equips their facility with elective and probably not as highly needed equipment.***

No place in the legislation does it specify to go back to pervious fiscal years to fund equipment purchases. Mr. Simcosky was told the California Tribal representative pushed for this addition so that some of the Clinics in California would be eligible. It is not clear whether this person was a true Tribal representative or a representative of one of the Clinic consortiums. ***None the less, this is clearly an addition which was not in the legislation and which could hurt the more needy and current construction projects.***

Summary

I'd like to conclude this letter Dr. Trujillo, to say that we are very disappointed and upset with the process to develop this formula and with the approved formula itself. Our Tribal representatives were completely ignored, the process has been slow and secretive and there has been no testing of the formula for fairness or accuracy.

Furthermore, we are told that the work group members felt larger Tribes are needier than smaller Tribes. *We hope this is not your opinion.* I am sure it is not Congressman Dick's opinion. We ask that you guarantee that the final disbursement of funds is fair and that small, non-remote Tribes are represented in a distribution curve of the funds equal to larger Tribes (based on percentage of scored forms). **In fact, the *Space Need Factor* and the *Location Factor* portions of the formula should be re-examined and changed before a final disbursement is made.**

It is always difficult to determine need. It is our opinion that concentrating so hard on this aspect, you have actually opened the doors so wide that the truly needy will be unfairly denied. All legislation talks about disbursement to the neediest. It doesn't say you need to open it up for the last four years or that IHS has to develop a formula engineered by staff who have no real experience in common sense. *You might be able to determine basic needs over elective needs*, but to say one type of Tribe is needier than another because of location or size is an unfair interpretation of the law. The idea should be to develop a fair formula for *FY 1995 projects only* and a formula which doesn't search for need based on subjective factors like location and Tribal size.

We are very excited about our new Health Center We will finally be able to offer collaborative health programs which concentrate on health promotion and prevention Please understand that we don't feel IHS is purposely developing a formula which favors one type of Tribe over another Rather, we feel this is a perfect example of what happens when Tribal advice is ignored and when no input or feedback is sought by those who developed the formula

I apologize over the length of this letter but feel it is important to logically clarify our concerns The Squaxin Island Tribe stands to lose or gain close to $100,000 Please feel free to contact myself or Mr Simcosky for any questions or clarification Thank you

Sincerely,

David Lopeman
Chairman

cc

Congressman Norm Dicks
Senator John McCain
Luana Reyes, IHS
Gary Hartz, IHS
James Floyd, IHS

ABERDEEN AREA TRIBAL CHAIRMENS' HEALTH BOARD

Aberdeen, SD 57401

Berkshire Plaza Suite 205
405 Eighth Ave NW

Administrative Offices:
Alcohol Related Developmental Disabilities
Finance
Northern Plains Healthy Start

Phone 605-229-3846
Fax 605-229-2174
Fax 605-229-6893
Fax 605-229-5864

Cheyenne River Sioux Tribe
Crow Creek Sioux Tribe
Devils Lake Sioux Tribe
Flandreau Santee Sioux Tribe
Lower Brule Sioux Tribe
Oglala Sioux Tribe
Omaha Tribe of Nebraska
Ponca Tribe of Nebraska
Rapid City Indian Health Board
Rosebud Sioux Tribe
Sac & Fox Tribe of the Mississippi in Iowa
Santee Sioux Tribe of Nebraska
Sisseton/Wahpeton Sioux Tribe
Standing Rock Sioux Tribe
Three Affiliated Tribes
Trenton Indian Service Area
Turtle Mountain Band of Chippewa
Winnebago Tribe of Nebraska
Yankton Sioux Tribe

April 27, 1995

Senator John R. McCain
Senate Russell Bldg. Rm 111
Constitution Avenue
Washington, D. C. 20510

Dear Senator McCain,

I am Russell Mason, Chairman of the Three Affiliated Tribes of North Dakota. On behalf of John Blackhawk, Chairman of the Winnebago Tribe of Nebraska and of the Aberdeen Area Tribal Chairmens' Health Board, we take this opportunity to present the health care issues of the Aberdeen Area Tribal Chairmens' Health Board:

1. Tribal Governments who contract utilizing the 638 mechanism must be funded at 100% for contract support. This resource support should be at least equal to the approximately 90% overhead costs currently allowed for the federal agencies.

2. Resource savings realized from redesign of Indian Health Services, must be directed to fill the unmet health care needs of the Aberdeen Area Tribes, at the local service delivery sites.

3. There are seventeen tribes within the Aberdeen Area, there are also two service units represented on the Board. We have a severe shortage of medical care providers. Due to the lack of adequate staff, the Doctors experience burn-out because of the overwhelming work load. The process for recruitment and retention of medical providers must be revised to ensure that adequate medical providers are available and salaried, to compensate for the requirements of

serving in isolated and needy service units. One-Third of the positions for medical doctors in the Aberdeen Area are unfilled.

4. The AATCHB supported Resolution 95-06 (attached) for the management and administration of the Aberdeen Area Regional Youth Treatment Center. The current budgeted amount of $1,337,038.00 will not be adequate to provide treatment for the projected 180 annual clients, employ 28-32 staff at an approximate payroll of $1,243,000.00 and pay the overhead costs of managing the facility and providing the treatment of the Youth of the Aberdeen Area. Preliminary projections of current need are an additional one-time $1 m. over and above the current $1.3 m. These needs include the cost of providing special health care and treatment, renovation of a recreation area/facility, adequate staff support costs and completion of the outside grounds of the Youth Regional Treatment Center which is located in Wakpala, South Dakota. Additionally, a continuing allocation which considers the cost of living increases and cost of business, annually must be included to maintain the Center.

5. The Aberdeen Area Tribal Chairmens' Health Board Tribes have not opted to compact under the Self-Governance process for several concrete reasons:

a. The Tribes of the Aberdeen Area expect the Federal Government and it's agencies to honor their committments to "elevate the health status of Tribal People to the highest possible level", in a organized and focused manner, which involves the Tribal Governments in plans and processes.

b. The Compacting process is still a demonstration program and has not proven to be effective or fair to all the Tribes of the Nation.

c. We, as non-compacting Tribes, have repeatedly requested orientation and information on the current demonstration project from Indian Health Service and have received no response to date to these requests.

c. The Aberdeen Area Tribal Governments are mainly large Tribes with a vast land base and approximately 107,583 tribal members who receive health care through Indian Health Service. As governments, the concerns of the elected leaders far exceed those Tribes or Bands who have small land bases and a much smaller population. It is necessary for our Leaders to move with caution and care in the provision of governmental actions and decisions which effect the welfare of tribal members.

6. In the redesign of Indian Health Service and the current work group focus must be on the actual health status of tribal people across the Nation. As formulas and factors are weighed for inclusion in resource allocation, a major consideration has to be the realities of tribal health status. This should be a major factor of any changes from the current formulas; to ensure that the mission of the Indian Health Service is achieved and measurable.

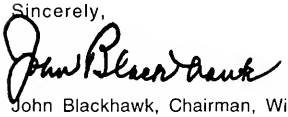
7. Maintain the current level of IHS Service Unit funding for the health care of Tribal People by increasing the funding for Hospitals and Clinics, Contract Health Care, and prevention programs and projects. Maintain the current level of funding for Emergency Medical Services. These services provided needed services in rural and isolated geographical areas. Ensure the maintenance of the Community Health Representatives Program as they fill a need in areas where primary health care providers lacking.

8. The National Heathy Start Project should be maintained and refunded to ensure an additional 2-3 years of continuation. The Northern Plains Healthy Start Project is showing a reduction in the Infant Mortality Rate from: 18.4% in 1989, to: 10.36 % in 1991, 12.45% in 1992, and 12.85% in 1993. The figures for 1994 are being established currently. The rise in statistical figures shows that the reporting of births and deaths are now being coordinated with the States and are therefore more accurate. Some of the reported deaths are not within the Reservation Healthy Start service areas, but are still reported as Tribal Infant Mortality. We would recommend that the National Healthy Start Project be refunded at $110 M. In 1997, 1998 and 1999.

Page 4.

Senator, these are some of the primary concerns of the Aberdeen Area Tribal Chairmens' Health Board. Thank you for your review and consideration of our concerns.

Sincerely,



John Blackhawk, Chairman, Winnebago Tribe of Nebraska
& The Aberdeen Area Tribal Chairmens' Health Board

cc: AATCHB Chairmen
AAO/IHS Area Director
AA/Health Directors

ABERDEEN AREA TRIBAL CHAIRMENS' HEALTH BOARD

Resolution 95-06

To Support and Concur with the recommendations of the Chief Gall Standards Committee regarding the management and administration of the Regional Adolescent Treatment Center for the Aberdeen Area.

WHEREAS, The Aberdeen Area Tribal Chairmens' Health Board (AATCHB) is composed of seventeen (17) Tribes and two (2) Health Organizations in a four State area; North Dakota, South Dakota, Nebraska and Iowa, and,

WHEREAS, The Aberdeen Area Tribal Chairmens' Health Board is primarily responsible for the health concerns and need of Tribes in the Aberdeen Area, and

WHEREAS, The Aberdeen Area Tribes, through concession of lands and other natural resources; through negotiated treaty provisions with the United States Government, have paid for their health care and therefore cannot be treated as general public citizens, and

WHEREAS, The Board has supported the establishment of the Chief Gall Youth Regional Treatment Center on the Standing Rock Sioux Tribal Reservation, near Wakpala, South Dakota through resolutions; 89-03, 91-03, 91-05, 91-13, 91-14, 91-43, 91-44 and 92-28, and

WHEREAS, The AATCHB has established the Chief Gall Standards Committee by Board action and appointed them the task of recommending to the Board the directions for the Treatment Center, through this means of tribal consultation, and

WHEREAS, The Standards Committe have made formal recommendations to the AATCHB at the January Quarterly Meeting held at Aberdeen, South Dakota at the White House Inn, and

WHEREAS, The AATCHB, by a majority vote, accepted all the recommendations of the Standards Committee,

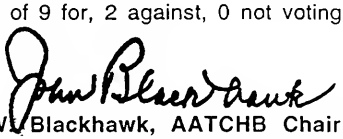
NOW THEREFORE BE IT RESOLVED, that the AATCHB Central Office Staff is hereby directed to begin preparation of a 93-638 Proposal for the purpose of managing the day-to-day operations of the Aberdeen Area Youth Regional Treatment Center, (AA YRTC) in behalf of the Board and the Aberdeen Area Tribes,

BE IT FUTHER RESOLVED, that the AATCHB requests that the Executive Director and Executive Staff prepare a proposal preparation timeline for Board consideration, and establish a planning committee composed of those parties who have vested interest and can provide technical assistance to the preparation of the proposal,

BE IT FINALLY RESOLVED, that the AATCHB directs that the 93-638 proposal for the operations of the AA YRTC be completed in a timely manner with the necessary supporting resolutions, to be solicited and received from Tribes of the Aberdeen Area.

CERTIFICATION

This is to certify that the foregoing resolution was duly adopted by the Aberdeen Area Tribal Chairmens' Health Board on January 20, 1995, during the first quarterly meeting of the Board, at the White House Inn, Aberdeen, South Dakota, by a vote of 9 for, 2 against, 0 not voting and 8 absent.



John W. Blackhawk, AATCHB Chairman
and Chairman of the Winnebago Tribe of Nebraska

Everette Enno, AATCHB Secretary
and Chairman of the Trenton Indian Service Area Health Board

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